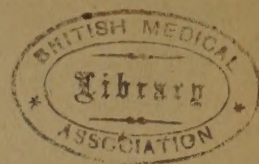
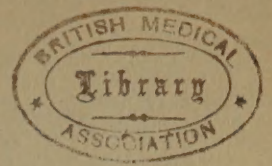




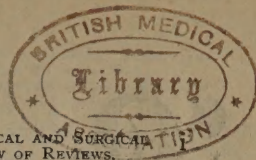
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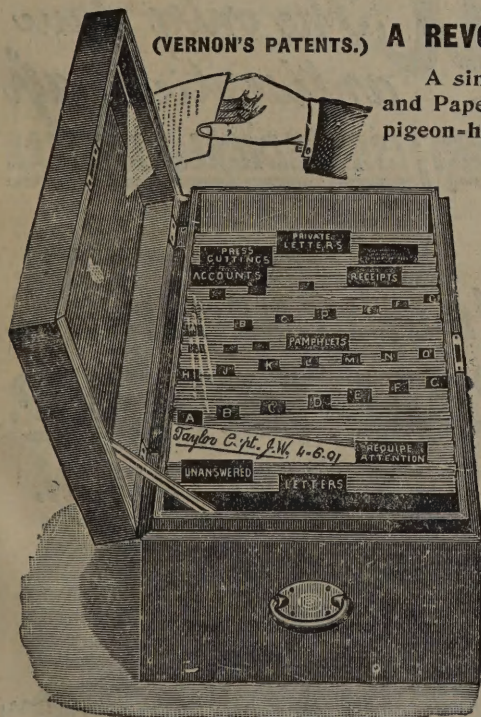


The Medical and Surgical Review of Reviews.

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The

Medical and Surgical Review of Reviews

A MONTHLY SUMMARY OF THE BEST IN THE MEDICAL AND SURGICAL PERIODICAL
LITERATURE OF THE WORLD.

VOL. I.

OCTOBER, 1898.

No. 1.

ANNOUNCEMENT.



WHEN Mr. Stead started his now widely popular magazine the "Review of Reviews," he prefaced his introductory remarks with the statement that the public was already provided with more periodicals than anyone could find time to read, giving this fact as his reason for adding another to the list, the new publication not to be a rival, but an index and guide to the magazines and reviews already in existence. Thus it is with the MEDICAL AND SURGICAL REVIEW OF REVIEWS, which is not intended to rival or in any way take the place of the established Medical and Surgical Journals, many of which fill such an important and useful part in professional life.

The remarkable success of Mr. Stead's publication having demonstrated the unquestionable utility of such a monthly compendium of the most important articles and best thoughts to be found in current periodical literature, the need of a professional magazine upon similar lines, dealing with professional subjects only, has become apparent, and the MEDICAL AND SURGICAL REVIEW OF REVIEWS has been founded to serve as a like index and guide to current medical and surgical periodicals—a focus of the theoretical and practical advancement of medicine and surgery throughout the world.

As the average man of affairs cannot find time to read more than a limited number of the principal magazines of the month, so the average practitioner finds it impossible to spare sufficient time for more than a cursory perusal of a few of the leading professional journals; the "Lancet," "British Medical," "Practitioner," or other favourite publication sufficing, as a rule, for

the leisure at his disposal. Obviously a great deal of useful up-to-date information escapes his notice. The exhaustive details of special cases reported in the medical and surgical journals, and the considerable space devoted to important articles dealing at length with special and local topics, necessarily preclude the possibility of more than a comparatively brief record of general progress. It follows that much that would be of great interest to many members of the profession is crowded out, and consequently the busy practitioner not only fails to keep fully informed as to the achievements of thoughtful students and skilled investigators in other parts of the world, who from time to time publish in their local journals the results of their studies and investigations, but the history of the peculiarities of exceptional cases, and their successful treatment with new or hitherto untried remedies, often remain for years, and not infrequently for ever, lost to the bulk of the profession.

By careful research, prompted by a spirit of scientific inquiry, and as the result of long experience and accurate clinical observation, many comparatively obscure physicians and surgeons have undoubtedly made important discoveries, which, reported in local magazines limited in circulation to small circles, never attract sufficient attention to lead to their general adoption in practice, the discovery often dying with the discoverer, leaving the world the poorer.

Perhaps an unusual form of a recognised disease, say carcinoma of the spleen—first described by Gaucher (Th. Doct., Paris) in 1882, or the diagnosis of an obscure lesion—a calcified fibroid of the uterus (Yamagiwa of Tokio, Virchow's Archive, vol. CXLIV. Part 1, 1896) for example, is reported, with history and treatment, in a

medical journal in San Francisco or Buda Pest, not always of sufficient importance to attract the general notice of the professional press, but possibly of very great interest to the physician attending a similar case in Melbourne, Pretoria, New Orleans, South London, or Glasgow.

THE MEDICAL AND SURGICAL REVIEW OF REVIEWS will endeavour not only to record from month to month the discoveries and progress of the profession as established by the savants of our time, but, so far as it will be possible to do so, every feature of interest appearing in the current medical and surgical literature of civilised countries will be adequately mentioned. The leading articles in the medical and surgical journals, when of general interest or distinctive value, will be reviewed, briefly but comprehensively; and if a physician of Cologne, Chicago, Lyons, or elsewhere, reports in his local or other medical journal the history of an interesting or uncommon case, or that he has succeeded in demonstrating the efficacy of a certain remedy in the treatment of a particular disease, or records the discovery and successful use of a new remedy or method of treatment, the essential features of his report will be found in our columns.

Should any of our readers or correspondents desire more complete details than appear in our pages, a full copy of the original article may be obtained by applying to our Enquiry Department. Copies of all the principal professional periodicals of the world will be on file, and open to inspection, at our London Office. Duplicate copies will be supplied at cost price, and typewritten copies of any particular article or report mentioned in the MEDICAL AND SURGICAL REVIEW OF REVIEWS will be forwarded on application, a nominal charge only being made to cover cost of postage and typing.

AN ANNUAL INDEX will be published, by the aid of which the student or writer will be able to easily ascertain in what journals articles on any professional subject, or reports of special cases, or classes of cases, may be found.

Although the chief object of the MEDICAL AND SURGICAL REVIEW OF REVIEWS will be to sum-

marise, in a readable form, and index the principal contents of the professional journals of the current month—everything, in fact, of general interest pertaining to medicine and surgery, as apart from matter of local interest purely, and worth filing for future reference, our *résumé* of periodical medical and surgical literature will be supplemented by a concise survey of important events relating to the profession, and occasionally by special articles upon the topics of the month. From time to time we will also publish in our columns original papers by eminent members of the profession, dealing always with the question of the day, and, when occasion justifies, a biographical sketch of some distinguished physician or surgeon will be included.

In addition to a monthly alphabetical index of the leading contents of the current medical and surgical periodicals of the world, a carefully selected list of the best books on medicine and surgery and allied sciences issued during the month will be given. Every book of importance will be reviewed, and, when possible, its price will be stated as a guide to intending purchasers.

Students and practitioners of medicine or surgery will, we believe, find the volumes of the MEDICAL AND SURGICAL REVIEW OF REVIEWS, with their accompanying Index, an indispensable work of reference, one which will render all that is new and important in the way of information relative to all branches of medicine and surgery readily accessible. The physician or surgeon anxious to profit by the observation and experience of his fellow practitioners, and desirous of keeping in touch with the current progress of his profession and thoroughly abreast of the times, will, we venture to anticipate, soon come to regard his bound copies of the MEDICAL AND SURGICAL REVIEW OF REVIEWS as primary necessities.

In promising so much, we would say that it is not by present promises that we wish the MEDICAL AND SURGICAL REVIEW OF REVIEWS to be judged. We realise that actual performance alone can afford a correct estimate of the value of the scope and spirit of such an undertaking, but we feel that we can confidently appeal from the present to the future,

NOTES.

The crusade against consumption is essentially a step in the right direction. In other countries, notably in America, France, and Russia, energetic efforts have been made to scientifically combat the disease. For some reason, difficult to understand, Great Britain has until recently neglected to make any organised attempt to deal with the subject in a scientific way. A majority of the profession now consider consumption curable, and there are sanatoria in various parts of the world in which consumptives have already been treated with marked success. In America the problem has received much attention, and over six years ago a French commission of medico-scientists was sent on a tour of the world with the object of deciding upon the most favourable spot for the treatment of pulmonary diseases. Southern New Mexico was finally selected by the delegates of the Société Médicale as the most favourable site for a consumptive sanatorium; the combination of almost perpetual sunshine, warm winters, considerable elevation, and dry aseptic atmosphere found in the southern counties of New Mexico affording conditions more favourable than those of any other locality.

Sir Samuel Wilks, in an article on the treatment of consumption in a recent number of the *Practitioner*, emphasises the fact that fresh air and sunshine are the chief remedial requirements of the consumptive. Fresh air is certainly of the greatest importance, the drier the better. The four characteristics which must prevail in a locality to constitute it a perfect wintering-place for those affected by pulmonary diseases are: (1) A small range of variation in temperature. (2) A maximum of sunshine. (3) A light, porous, dry soil. (4) An atmosphere free from moisture. Southern New Mexico affords these requisite conditions; the altitude is about 3,500 feet, sufficiently high to be bracing and yet not high enough to embarrass the heart's action or increase dyspnoea. The soil is sandy and porous, and the rainfall rarely exceeds six or eight inches per annum. The proportion of sunny to cloudy days is ten to one, and a day clouded throughout its entirety is practically unknown. The freedom of the atmosphere from moisture is phenomenal.

Even in England, tuberculosis is frequently amenable to treatment in its early stages, and permanent cures are occasionally effected; but in the present state of our knowledge infinitely more is to be expected from preventive measures than from attempts to cure. Whilst we await the discovery of an antitoxin capable of successfully combating the bacillus of tubercle, our efforts should be chiefly devoted to prophylaxis, and here we have abundance of work ready to hand, in educating the public to greater care in the prevention of the spread of infection.

It is now believed that all cases, both in man and the lower animals, are produced directly from infection derived from without, and that hereditary predisposition merely renders the subject more prone to attack. This is the experience of every general practitioner. How often do we find husband and wife infecting each other, and to what an enormous extent must this deadly process go on in crowded assemblages, such as schools, churches, places of entertainment, railway carriages, and other places where people are massed together in large numbers! It is evident, therefore, that by paying due regard to the recognised conditions of prevention, much may be done to limit the prevalence of this fearful scourge.

Manifestly our present system of aggregating the victims of tuberculosis in the general wards of our hospitals is most pernicious. Special hospitals should be provided for tuberculous patients, in the same way that we now provide for those suffering from scarlatina or diphtheria. The disinfection of all rooms occupied by tuberculous patients should be rigorously enforced by law, and for the proper carrying out of this proceeding it is worth considering whether tuberculosis should not be included in the list of diseases to be notified to the medical officer of health. Again, more attention should be paid to the veterinary inspection of our food supplies, tuberculosis being present to an alarming extent in those animals from which our beef, milk, butter, and cheese are derived. Such inspection at present is very far from adequate. Even were an efficient antitoxin discovered to-morrow, prophylactic precautions would be none the less necessary.

The *British Medical Journal*, in an interesting article on the subject of the murder of the late Empress of Austria, calls attention to the error of the popular belief that a wound in the heart invariably results in instantaneous death, and points out that the victim usually lives for several minutes after the wound has been inflicted, that is, until sufficient blood has been forced out of the wound into the pericardium to cause fatal compression of the heart from without.

In the more suddenly fatal cases, blood escapes freely into the mediastinum through a wound in the pericardium, or death is immediate from shock due to injury to the sympathetic or pneumogastric nerve. It has, of course, long been known to surgeons that immediate death does not always follow a wound of this description. Paré, in 1552, reported the case of a duellist who, after receiving a sword thrust in the heart large enough to admit the finger, pursued his opponent for 200 paces and then fell dead. Billy, in 1680, described the case of a patient who lived five days after the right auricle had been wounded by a sword thrust.

Four instances of gunshot wounds of the heart, not immediately fatal, appear in the "Reports of the Medical and Surgical History of the War of the Rebellion," published in Washington in 1870. The first patient survived for fourteen days a wound in the right auricle caused by a round musket ball. The second lived an hour and a quarter after perforation of the right auricle and left ventricle by a pistol ball. The third suffered from perforation of the left auricle and left ventricle in addition to gunshot wounds of the intestine, axilla, and lung, and yet lived forty-six hours. The fourth patient was wounded in the right auricle by a musket ball; he died two and a-half years later.

Another case is recorded, having a close resemblance to that of the murdered Empress. The patient had inflicted, with a large sheath knife, several stabs on an assailant, who seized his wrist, turned the point of the knife towards him, and suddenly drove the blade with great force into his chest, the handle still being grasped in the owner's hand. The wounded man fell at once, gasping for breath, his face deadly pale, and died in about eight minutes. The blade of the knife had pierced

the sternum, traversed the mediastinum, and freely opened the right auricle. The cavities of the heart were empty, the sac of the pericardium and mediastinum were filled with blood; the blood partly escaped into the pericardial cavity, thus causing fatal compression, probably before the system had suffered sufficient loss of blood to destroy life.

The *Lancet* reports an even more remarkable case, described by Dr. Parlavecchio at a meeting of the Società Lancisiana, held in Rome on July 9, of a punctured wound of the heart operated upon successfully. On the night of July 7th, a man, twenty years of age, was stabbed with a knife in the fifth intercostal space on the left side in the parasternal line. He afterwards walked to the hospital, a distance of more than two hundred yards. Five hours later he was found to be suffering from pneumothorax on the left side, with extensive effusion of blood into the pleura. Dr. Parlavecchio suspected a wound of the heart, but was not able to operate until eight hours after the injury. Chloroform was given, and a free incision made in the fifth intercostal space. Much blood escaped on opening the pleura. After resection of the fifth rib, a wound admitting two fingers was discovered in the pericardium, and was enlarged so as to expose the heart, in which there was, near the apex, a wound an inch and a-half long, penetrating obliquely into the left ventricle, and intermittently discharging blood. It was closed with four deeply-applied separate silk sutures, after which there was no further hæmorrhage. The pericardium and the intercostal wound were then sutured, the whole operation lasting forty minutes. According to the *Supplemento al Policlinico* of August 20, from which the report of the case is taken, the subsequent history was quite uneventful, and on August 14 the patient left the hospital. This is said to be the third case in which suture of a wound of the heart has been followed by recovery.

A public appeal has been made for a sum of £100,000, to be handed over to the trustees of the Institute of Preventive Medicine, Chelsea Embankment, for the purpose of founding a permanent memorial to commemorate the centenary of the discovery of vaccination by Dr. Jenner—the Institute of Preventive Medicine in the future to

be known as the Jenner Institute. The proposal to found a Jenner memorial was brought forward in 1896, but the then approaching Jubilee festivities rendered it expedient that the matter should be left for the time being in abeyance. The Government having achieved the supreme legislative folly of our generation, it is to be hoped that the amount required will be speedily raised, as no more appropriate time than the present could be determined upon for such a public recognition of the value of vaccination. Contemporary professional journals and others have already dealt fully with the absurdities of the new Vaccination Act, rendered practically inoperative by Clause 2, but the measure is of such vital importance that we have felt constrained to comment upon the subject at greater length elsewhere.

Considerable doubt seems to be entertained in many quarters as to the manner in which the "conscientious objection" is to be exercised under the Vaccination Act—whether parents must themselves take action within a specified period, or wait until they are summoned for non-vaccination. All uncertainty is removed by a careful perusal of the Act of Parliament. Section 2 runs as follows:—"No parent or other person shall be liable to any penalty under Section 29, or Section 31, of the Vaccination Act of 1867 if, within four months from the birth of the child, he satisfies two justices in petty sessions that he conscientiously believes that vaccination would be prejudicial to the health of the child, and within seven days thereafter delivers to the vaccination officer for the district a certificate by such justices of such conscientious objection."

Sir William Crookes' able Presidential Address before the British Association at Bristol affords both the economist and the chemist ample food for thought. England, of all civilised nations, stands in most deadly peril of a lack of wheaten bread, over 75 per cent. of the wheat supply being imported from abroad, and it is generally recognised that, failing American support, a war with two or more of the Continental naval Powers would gravely endanger the wheat supply.

Sir William maintains that a few years will exhaust Nature's visible store of nitrates, without

which the requisite wheat supply of the world cannot be maintained, and he asserts that our only safety depends upon an early discovery of a relatively inexpensive method of artificial production. He anticipates, however, that science will be equal to the demand, and that by the aid of electricity the atmosphere will become an economic source for all the nitrogen that may be required in artificially preparing suitable wheat manure, capable of largely increasing the productiveness of the wheat fields. According to Sir William's deductions, the fixation of nitrogen is vital to the progress of civilised humanity; without it, he thinks, the Caucasian race, for whom he evidently considers wheaten bread the staff of life, must succumb to other races. As he himself asserts that he has succeeded in making wheat manure out of air, we need not be unduly alarmed; the scientific skill of the President reassures us. Neither has it been conclusively demonstrated that wheat is essential to the physical or mental superiority of the Anglo-Saxon. We know of more than one healthy specimen who looks upon bread as the staff of death rather than as the staff of life, and who considers the excessive use of starch as food the chief cause of most of the physical ills of humanity.

Granting wheat to be a necessity, the interesting experiments that have been carried on since 1880 by Messrs. John and Robert Garton in the production of new varieties of cereals by means of cross-fertilisations may assist in paving the way for an adequate supply. The late Lord Winchelsea was greatly interested in the subject, and judging by the results obtained on his experimental farm near Sleaford, the problem of cross-fertilisation has been successfully solved. Messrs. Garton succeeded in producing varieties the average weight of which is 60 per cent. heavier than the average weight of grains in ordinary cultivation.

Dr. E. Buchner, Professor at Tübingen, delivered at Vienna, before the Third International Congress of Applied Chemistry, an address on the subject of fermentation without yeast cells, in which he described his method of producing fermentation by means of the liquor expressed from yeast. He stated that he infers from the result of his experiments that, contrary to

Pasteur's theory, living yeast cells are not necessary for the production of alcoholic fermentation, and that, consequently, fermentation is not a physiological process, but is caused by the substance called zymose. Professor Buchner's discovery, if substantiated, may, possibly, throw a new light on the theory of infectious diseases, and may lead to results of the utmost importance.

Dr. Clamette, Director of the Pasteur Institute at Lille, has succeeded in cultivating a fungoid growth which entirely replaces the yeast hitherto employed in the manufacture of alcohol. Trials on a large scale have proved the superiority of the cultivated fungi. Maize fermented by means of the fungi gives a much larger quantity and better quality of alcohol at much less expense, the spirit being cleaner and containing less empyreuma—owing to the absence of the microbes found in yeast. One thousand kilogrammes of corn require but a few grains of fungi for the purpose of fermentation. Dr. Clamette has further proved that this aseptic method of fermentation works with equal success in the factory and in the laboratory.

The most sensational event of the Congress, however, was Dr. Leo Lilienfeld's announcement of his alleged discovery of a method of producing artificial albumen, claimed to have the same nourishing qualities found in that obtained from organic beings. Professors Ludwig and Mauthner, of the Vienna University, professed to have no doubt as to the immense value of Lilienfeld's invention. The so-called discovery was heralded as "a great historic event of enormous consequence to the life of nations." It was asserted that one of the most difficult problems of organic chemistry had at last, after years of study, been satisfactorily solved, and that by the condensation of phenol and amydo-acetic acid with phosphorochloric-oxide a "pepton" giving all the tests of organic pepton had been produced. The discoverer performed the whole synthetic process and produced his artificial albumen before the members of the Congress. Highly ingenious theories were at once advanced as to the probable effect of the discovery upon the cost of mankind's principal food. In certain quarters it was at once concluded that all organic products containing albumen would soon be replaced by manufactured

articles. Any such deduction is of course obviously premature.

The product of Lilienfeld's process may give the tests of real pepton, but it does not follow that he has succeeded in producing a pure proteid. Both in France and in England similar discoveries have been made during the last few years. Professor Grimaux, the distinguished French savant, published his report in 1898. Dr. Pickering, of King's College, the well-known writer on physiological subjects, published in 1895-6 the result of his investigations. Lilienfeld's "invention" only carries us one stage further in a series of experiments, extremely interesting for chemists, but which may never have any practical or commercial value, as artificial substitutes for organic products have, so far, always been much more costly than the genuine article. The substance produced by Dr. Pickering differs from albumen only in being less heavy and less susceptible to polarised light; it even possesses the deadly characteristics of albumen, and when introduced into the circulation proves instantly fatal. The cost of production is prohibitive, and the nutritive value of the new compound is practically nil.

Although Lilienfeld's claim to have discovered a means of making albumen, to be used as a substitute for food, is certainly premature, it is not unreasonable to anticipate that investigators are on the eve of a great scientific advance. Someone, working on the lines now suggested, may one day solve the problem, and revolutionise the food supply of the world. Already many of the essential ingredients of bread stuffs have been produced artificially.

According to Dr. A. Bethe the scent of man is acquired, and is not born with us, but he, in one particular, at least, extends the Jager theory even further than its original projector, and affirms that, like many of the lower animals, some men are gifted with an exceptional nasal sensibility and can detect a man by his distinctive and individual smell. Experiments were made with a person thus exceptionally gifted, who was taken with bandaged eyes into a room where more than twenty persons of his acquaintance had been collected. Everyone was detected and named

correctly by the "smeller." Dr. Bethe believes that there is a characteristic "family smell," of which each member of a family more or less partakes, and which they do not wholly lose, even when they are separated from one another for years. It may be mentioned, however, that he warns us against hasty conclusions regarding a matter which is still in a tentative stage only, particularly as man's individual scent is largely the result of his social environment and his personal habits and mode of life.

An anonymous writer has published in the *Allgemeine Zeitung* an enthusiastic glorification of sugar. He points out that the negroes on Southern plantations refresh and strengthen their weary bodies by "sucking" the sugar cane. A Dutch army surgeon states that during an expedition in Sumatra he found that the best means of maintaining his soldiers' vigour and freshness, especially during long marches, was to serve each man with a generous allowance of sugar. The Swiss chamois hunters bear similar evidence in support of its powers of sustenance and invigoration after exhausting fatigue. Successful experiments have been made with sugar as a food for athletes by several Dutch rowing clubs, by pedestrians, cyclists, and others. Sugar is coming more and more into use in Holland in the course of training for physical contests. It is the fruit acid in sweets which is injurious to the teeth. Negroes, who consume sugar in such huge quantities, almost invariably have perfect teeth.

A special committee of the London Chamber of Commerce has lately been engaged in investigating cases of alleged poisoning through eating tinned foods, with the result that it has been decided that such allegations are almost invariably unfounded. In the late examination into the cause of the death of a young married woman at Tunbridge Wells, said to be due to ptomaine poisoning consequent upon eating tinned salmon, the coroner, after preliminary inquiries, communicated with the Home Office, by whose order the contents of the stomach were analysed by Dr. Stevenson, the official analyst. Dr. Stevenson reported that death had been distinctly caused by nitre poisoning, and could not be attributed to ptomaine poisoning from eating tinned salmon. He expressed the

opinion that the proportion of cases of poisoning through eating tinned foods was infinitesimal, and that so far from all ptomaine poisoning being specially identified with tinned provisions, it also arises in connection with fresh meats of all kinds.

The Sirdar's Nile Expedition and the late operations of the United States troops in Cuba have much interest for the surgeon. Military and naval experts have long looked forward with scientific curiosity and impatience for an opportunity to adequately test, in actual warfare, new and important improvements in arms and ordnance; whilst enthusiasts in the realm of medical science and inquiry have likewise been naturally desirous of an opportunity to demonstrate the value of modern discoveries and improvements in surgery as applied on the field of battle. The character of the wounds inflicted by modern arms demands more than usual skill on the part of the surgeon. Heretofore abdominal surgery in the field has been almost impossible, but with the aseptic methods now in use, abdominal wounds received in battle, especially on shipboard, have given little less difficulty than is experienced with the ordinary cases in hospitals. Many other kinds of wounds formerly deemed incurable, despite the utmost skill and care, have now been successfully treated. While the implements of destruction have been multiplied and rendered more deadly and effective, there has been like progress in remedial agencies, and the vast improvements in surgical equipment and appliances, for the most part strangely conspicuous by their absence in the Cuban campaign, but amply in evidence with the Sirdar's forces, have naturally done much to save life and alleviate suffering.

In a work on the morphine habit lately published in Paris, much interesting information concerning morphinism and morphinomania is given. It is stated that Germany, France, and the United States are the countries in which the vice is most common. Statistics are furnished of 1,000 cases collected from all parts of the world—650 men and 350 women. These statistics show that, of the males, the medical profession supplied the largest number, 40 per cent.; men of leisure come next with 15 per cent.; then merchants, 8 per cent.; peasants, clergymen, and politicians occupied the

lowest position on the list. Women of means constitute the most numerous class among the female morphinists, 43 per cent.; followed by wives of medical men, 10 per cent. It is said that in Germany there are entire villages whose inhabitants are addicted to the use of morphine, but the general belief that the morphine habit is more extensively practised in Paris than in any other city is contradicted. Morphinomania occurs with the greatest frequency between the ages of twenty-five and forty. The direct action that morphine exercises on the organs of generation in both sexes, producing impotence in the male and amenorrhea in the female, is well attested.

September 16th was the 160th anniversary of the death of Gabriel Daniel Fahrenheit, who invented the thermometer, and who gave his name to the most familiar system of thermometrical notation. He was an unsuccessful merchant of Dantzic, who turned his attention to chemistry, and succeeded in perfecting the mercury thermometer. His system of notation is an arbitrary one, and there can be no doubt that the Centigrade system, invented by Celsius, which allows 100 degrees between freezing point and boiling point, is the more satisfactory. The Réaumur system is widely adopted in France, and is practically the only system in use in Russia.

The gruesome subject of premature burial has again been attracting considerable attention in Russia and Austria, where several cases have recently been reported, and the need of a scientific test of death has suggested the use of Röntgen rays. The slightest movement of the heart blurs the skiagraph, and in Paris the Xrays have already been successfully used as a test of death.

The following extraordinary instance of coincidence is reported in the *Lancet*:—A patient at the age of ten years fractured his right index finger. It happened on August 26. When thirteen years old he fractured his left leg below the knee, through falling from horseback, also on August 26. When fourteen years of age he fractured both bones of the left forearm by stumbling, his arm striking the edge of a brick, this also happened on August 26. When fifteen years of age, on August 26, he had a compound fracture of the left leg above the ankle, by his left foot being caught under an iron rod and

his body falling forwards. Next year, again on the same date, August 26, he had compound fracture of both legs. After this he did not work on August 26 for twenty-eight years; but in the year 1890 he forgot his fateful day and went to work, with the result that he sustained a compound fracture of the left leg. Since then he has studiously avoided working on August 26, though never missing work at other times.

It is publicly stated that there has been an important secession from the ranks of the vegetarians, the entire Dominican Order in England having received permission from Rome to eat flesh four days a week, instead of perpetually abstaining as heretofore. In cases of ill-health or specially hard work, meat is to be allowed six days a week. This decision has been arrived at after the closest medical and official investigation of the effects of perpetual abstinence from meat in a variable climate like that of England; the result being that vegetarianism has been declared incompatible with physical strength and hard work.

We have received many encouraging letters from all parts of the country favourably commenting upon the merit of our undertaking, and not a few have favoured us with advice as well as approval—both equally welcome, which leads us to hope that this our initial Number may, perhaps, receive more favourable criticism than it deserves. Many of the journals we intended summarising came to hand too late for this issue, and part of our staff is upon trial. We shall retain the service of those who evince a special aptitude for brief, clear, and yet adequate epitomising, and shall endeavour to secure the co-operation of a corps of assistant editors who will leave nothing to be desired.

Some surprise has been expressed that no attempt has been made to identify the names of prominent members of the profession with this journal. The answer is a simple one. Leading Physicians, Surgeons, and Specialists have no time for other than original work. The character of our reviews, summaries, and epitomes necessarily requires a vast amount of constant general reading, and much time must be devoted to the careful elimination of useless verbiage. It is a

popular fallacy that no great amount of care is required for epitomising; as a matter of fact, the converse is the case. The bare mention of a few of the leading features of an article generally possesses but little value, and much thoughtful attention is necessary in condensing an article, say, of three or four pages, into half a column or less without sacrificing lucidity or suppressing important details. If the profession finds the MEDICAL AND SURGICAL REVIEW OF REVIEWS useful, it will fulfil its object, and without the aid of ornamental figureheads.

Vaccination.

THE one redeeming feature of the Vaccination Act, which received the Royal Assent just before Parliament rose, was the substitution of glycerinated calf lymph for that of human lymph. Most practitioners, it is true, have for some years used nothing else, but the Local Government Board, so far from encouraging its use, has hitherto actually penalised public vaccinators who used it by depriving them of their awards. In other respects the new Act marks a distinct departure from the path of safety, and calls for nothing but the hostile criticism which all medical journals and leading organs of public opinion have bestowed upon it with significant unanimity.

Unquestionably the vast majority of the profession are agreed that if anything in medicine has been demonstrated beyond dispute it is the great value of vaccination, with its corollary of re-vaccination at intervals. But the objectors to vaccination calmly put aside expert evidence by the uncomplimentary suggestion that medical men have a monetary interest in compulsory vaccination, when it is notorious that the profession has never—indeed, has not sufficiently—considered the financial side of its work. If pecuniary advantage were our sole consideration, as alleged, it is obvious that frequent and widespread epidemics of small-pox would prove infinitely more remunerative than the small fees derived from vaccination. But outside of the profession there is abundant testimony to the value of vaccination; the experience of the postal service, and of the army and navy would alone be sufficient. The Vaccination Commission, which could not be accused of undue haste in presenting its report, definitely decided

that the value of vaccination was conclusively established by the evidence they had collected.

The conscientious objectors, who cannot deny the enormous decrease in the prevalence of small-pox since Jenner's great discovery, attribute the decrease entirely to the advance in knowledge of sanitary science. Improved sanitary conditions have no doubt had an appreciable effect on small-pox, as on other zymotic diseases, but the result in no way accounts for the fact that in any given epidemic of smallpox the incidence of the disease is very largely to the disadvantage of the unprotected.

That disease has been communicated by taking lymph from unhealthy children may at once be granted; but that this can occur where due precautions are taken it is impossible to believe. The care taken at all the establishments for the collection of calf lymph is in every way satisfactory, bacteriological examination being carefully made both before and after the calves are inoculated, and all lymph to which the slightest suspicion attaches being rejected as unfit. Thus the anti-vaccinator is deprived of the one reasonable objection which he has ever been able to submit, although it is open to argument whether the few disasters which occurred under the old system were not amply compensated for by the immense saving effected in human life and suffering.

We maintain that vaccination and re-vaccination, *efficiently performed*, confers almost absolute protection against an attack of smallpox; whilst even inefficient vaccination will do much to prevent the pitting with which our seniors were so familiar. A generation ago every second or third person was disfigured in this way; now long immunity has begotten indifference and forgetfulness. Did the recent surrender of Parliament to the narrow prejudices of a small but aggressive minority indicate that in the minds of our rulers some doubt had arisen as to the efficacy and value of vaccination, we might understand—though we could not sympathise with—their position. But so far from this being the case, it is curious to remember that speaker after speaker rose in his place in the House and proclaimed himself a firm believer in the protective properties of vaccination; clearly proving that the exigencies of Parliamentary tactics were deemed of more importance than the demands of health for the people. If, then, vaccination is the boon to humanity most of us believe it to be, it is of first

importance to determine the means by which its benefits can best be conferred on the public at large : these may be summed up in the one word, *Compulsion*.

All law and order depends in the last resort on the strong arm of the policeman. Nothing but ridicule and disaster can result from maintaining laws on the Statute Book which the public are invited to disregard by the intimation that an easy means of escape has been provided for the wilful breaker of the law, now euphoniously designated the "conscientious objector."

It would not be difficult to find conscientious objectors more numerous than the members of the Anti-Vaccination League who conscientiously object to the income-tax. It is probable that Bill Sykes regards the appointment of magistrates as an unwarranted interference with the liberty of the subject ; and many well-meaning persons of repute entirely disapprove of the licensing laws ; but none of these "conscientious objectors" are allowed to disobey with impunity the various Acts which they denounce, nor are the Peculiar People permitted to escape when they allow their children to die without medical aid. Manifest political expediency alone explains the action of our legislature in allowing the anti-vaccination faddist to evade the law of the land. Either vaccination is a valuable protection and ought to be rigidly enforced on all alike, including the "conscientious objector," or it is of no value, and the Vaccination Acts ought to be repealed. There is no middle course ; but it will apparently require the drastic and inevitable penalty of a widespread epidemic of variola to bring our legislators to a just recognition of the criminal folly of their unwisdom in sacrificing the common weal in the interest of party politics. Meanwhile, the wise will continue to protect themselves and their families by vaccination and re-vaccination ; the unwise will learn wisdom by bitter experience. Unfortunately, many will perish, and more will be disfigured for life through no personal fault, but solely owing to their misfortune in being the children of "conscientious objectors."

Masked Malaria:—Dr. L. P. Walbridge (*Med. Mir.*, St. Louis) urges that in many cases where our diagnosis is at fault, the trouble is really caused by malaria, and can be cured by quinine.

LEADING ARTICLES.

LANCET, Sept. 10, 1898.

Separation of the Lower Epiphysis of the Humerus with Displacement Forwards.

By MR. W. McADAM ECCLES.

A boy, aged ten, fell on his right hand. The elbow was painful but the injury was not thought serious enough to require advice. After four to five weeks a dimple could be seen about the tip of the olecranon process. The three bony prominences of the elbow bore their normal relation to one another, but appeared to be on a plane anterior to the shaft of the humerus when compared with the other side. Full extension of the elbow was impossible. A skiagraph showed that the ossific centres of the lower epiphysis were displaced forwards. The writer could find but few references to this form of displacement. The prognosis is good, provided early passive movement and massage are employed. In this case the patient had a useful limb with little deformity.

LANCET, August 27.

The Conservative Surgery of the Ovary.

CHRISTOPHER MARTIN, M.B., F.R.C.S.

The physiological value of the ovaries may be realised by noting that their complete removal is followed by :—(1) Amenorrhœa (in 95 per cent. of the cases). (2) Atrophy of the uterus and, to a less extent, of the vagina and vulva. (3) The nervous symptoms of the menopause. (4) Diminution or abolition of sexual instincts (in a majority of cases). (5) Obesity. If one ovary or only a portion of an ovary be left behind, these results do not ensue. It follows that in cases of cystoma of one ovary it is unjustifiable to remove both. But in sarcoma of one, both should be removed, for the growth is extremely apt to affect the second. In unilateral disease—salpingitis, ovarian abscess, &c.—the organs should be removed only on that side. In a case of ovarian abscess he removed the diseased (right) appendages. The left were buried in lymph, but not otherwise obviously affected. He simply freed them from adhesions. The patient was symptomatically cured, and became pregnant. In double pyosalpinx he performs vaginal hysterectomy and removes the tubes, but always

endeavours to leave one or both ovaries unless they are obviously diseased. On examining a number of specimens of fibroma of the ovary removed by operation, he found that the growth could easily be separated from the glandular portion of the ovary. It would have been better to have made an incision into the ovary, enucleated the fibroid, and sutured the capsule in these cases. In several cases, instead of removing cystic ovaries, he has performed resection with satisfactory results. The reckless way in which uterine appendages have been removed is an approbrium. In expressing these views, Mr. Martin states that he follows Martin, of Berlin, and Pozzi, of Paris; he might have added Howard Kelly, of Baltimore.

LANCET, August 13.

The Bacteriology of Cirrhosis of the Liver.

Professor J. G. Adami states that experiments on animals show that alcohol at most produces the fatty liver with a slight amount of fibroid change in the portal areas, and nothing at all resembling the deposit met in hob-nailed liver. Moreover, extreme cirrhosis may attack children and adults who have never taken a particle of alcohol. As the result of numerous bacteriological researches he concludes. (1) That in at least a very large number of well-marked cases of progressive cirrhosis in man a bacterium is to be found in the liver cells. (2) That in the infective cirrhosis of cattle a similar organism occurs. (3) That the organism may occur in other organs. If these observations are confirmed, cirrhosis of the liver assumes an entirely new aspect. A number of phenomena are satisfactorily explained, such as enlargement of the spleen before there are any signs of portal obstruction, and the frequency of right-sided pleurisy. The presence of jaundice in some cases and ascites in others perhaps depends upon whether the organism more especially affects the liver cells and bile ducts, or sets up a low inflammation of the peritoneum.

LANCET, August 13.

Erythromelalgia in Disease of the Spinal Cord.

Dr. James Collier publishes an important paper. The association of erythromelalgia with diseases of the central nervous system was noticed by Weir

Mitchell in first describing the condition in 1878, and has been observed by several writers, but never in this country. Erythromelalgia is characterised by acute and painful congestion of definite cutaneous areas; the skin becomes, in marked cases, purple-red and swollen. The limbs are usually affected, the face and trunk rarely. The lower limbs are more frequently affected than the upper. The distribution is not that of nerve-root or nerve-trunk, it is often limited by a sharply marked circular line round the limb. The condition shows a tendency to spread until the whole distal part of the limb is affected. It is usually symmetrical, though frequently one limb is affected before the other. The duration of the attacks varies from half-an-hour to several weeks; it is usually three or four hours. The attacks may appear spontaneously, or may be induced by exertion, warmth, or emotion. The effect of position is remarkable: if the foot be affected an attack may often be brought on by allowing it to hang down, and during the attack that position always increases the symptoms, whilst elevation relieves them. Dr. Collier observed ten cases in the National Hospital for the Paralysed and Epileptic during six months. The patients were subjects of disseminated sclerosis in five cases, tabes dorsalis in two, neurasthenia in two, and myelitis in one. The discovery of these cases in such a short period shows that erythromelalgia is not a rare symptom of spinal-cord disease; it has, no doubt, been frequently overlooked. In several cases the attacks were first spontaneous, then induced by posture; later, a condition of permanent vaso-motor palsy appeared, the attacks still continuing. This sequence suggests, as the cause of the phenomena, an irritative lesion of the vaso-motor centres, progressing to a paralytic one. The pain never preceded, but accompanied or followed the congestion; it seemed to be a local result of the latter. The writer lays stress on the fact that erythromelalgia may be the first symptom of organic disease of the spinal cord.

The Causes of Urinary Fever at the Beginning of Catheter Life.

C. Mansell Moullin (*Lancet*, September 10, 1898, p. 681) observes that serious symptoms not infrequently follow the withdrawal of residual urine, in cases of enlarged prostate, at the begin-

ning of catheter life. After a few days the urine becomes cloudy, lower in specific gravity; albumen, pus, and a few hyaline casts appear. The total daily amount may increase to seven or eight pints, or diminish to twenty ounces. There is seldom a definite rigor, but there may be slight chills. The pulse grows rapid and feeble; the tongue becomes red and dry; and there is considerable anorexia. Nocturnal delirium sets in, frequently terminating in coma and death. *Post mortem* recent acute cystitis and pyelonephritis are found. The pelvis and ureters are dilated, the apices of the renal pyramids are eaten away, the cortex is shrunken and hard, the capsule is adherent, and in places between the tubules are minute abscesses. The symptoms and appearances are inconsistent with the usually advanced explanation of too rapid evacuation of the bladder as their cause. The earliest sign that there is anything wrong is cystitis; it is always purulent and, therefore, caused by pyogenic microbes. The urine may retain its acid reaction, and there may be but little pain and strangury, but there is a distinct cloud, which leaves a greyish deposit, consisting of pus and bacteria. The deposit is not mucus. There is no such thing as catarrhal cystitis. Cystitis is always purulent. The symptoms do not present more than a vague resemblance to those of uræmia. They are essentially the symptoms of sub-acute septicæmia in a person whose health is broken down by chronic renal degeneration. They are caused by the growth of septic organisms in the urine, and walls of the urinary organs. The microbe most usually found is the bacillus coli communis, then the streptococcus, and then a proteus. The source of these organisms is the urethra. When a catheter is passed, they are carried into the bladder. If it is healthy and empties itself completely, no harm results—the organisms do not get the chance of growing. If not, they multiply, spread into the epithelial layer, and set up cystitis. One of the reasons why the real source of cystitis has been overlooked is that the inflammation has not been regarded as septic, because the urine had not undergone ammoniacal decomposition. But the worst forms of septic cystitis and urinary septicæmia may occur independently of ammoniacal decomposition, and with the urine distinctly and persistently acid. The septic pyelonephritis, which is always present in fatal cases, is the natural sequence of septic

cystitis. Dilation of the pelvis, and sclerosis and degeneration of the kidney, are inevitable in cases of long-standing residual urine. As in the bladder, so in the kidney, the power of resisting septic organisms is impaired.

Aseptic catheterism is a problem of modern surgery. All instruments must be boiled. The hands, prepuce, and skin of the penis must be cleansed with soap and water as if a surgical operation was about to be performed, and then sponged with sublimate solution 1 in 5,000. An irrigating catheter is then introduced into the foramen naviculare, which is washed out with boric acid; then the process is repeated in the deep part. Finally Melchior's double catheter is introduced, and the urine is drawn off. Melchior's double catheter consists of two tubes, one inside the other. The outer has a terminal orifice closed by a rubber film. When the outer is passed down to the neck of the bladder the inner is pushed on through it, rupturing the film. But in cases where frequent catheterism has to be performed all these precautions will never be carried out. However, catheters can be kept clean. Mr. Moullin recommends some made for him by Maw, and described in the *Lancet*, July 6, 1895, which will stand boiling day after day and continued immersion in boracic acid. Each patient is provided with two of the glass catheter cases devised by Dr. Nicoll, of Glasgow, which are filled with boric solution and used alternately.

LANCET, Sept. 10, 1898.

Rupture of the left Coronary Artery: Hæmopericardium Failure of Right Carotid and Radial Pulses.

By LAWRENCE HUMPHRY, M.D.

A woman, aged fifty-eight, in good health, whilst at breakfast complained of faintness and dizziness and was sick. When seen she was lying on the floor looking pale and anxious. She complained of pain in the stomach and numbness in the right arm. The right radial pulse was imperceptible, the left was 100, feeble, and irregular in force. The precordial dulness was not increased, and the heart sounds were feeble at the apex and a roughness was noticed with both at the base. The extremities were cold and clammy. She gradually became worse. The face was cyanosed and the

right jugular vein was prominent. Pulsation could not be felt in the right carotid or brachial arteries. But on turning the patient over on the left side the right radial pulse could be distinctly felt; it disappeared immediately on turning her on her back. Tubular breathing was heard at the angle of the right scapula. She died seventeen hours after the onset. At the necropsy the large veins of the neck were found distended. The pericardium bulged slightly and contained 5 or 6 ounces of blood-clot. The left coronary artery was ruptured about a quarter of an inch from its exit from the aorta. The heart was in advanced stage of fatty degeneration. There was much extravasation of blood into the muscular tissue and upwards into the fold of pericardium ensheathing the first part of the aorta. The result was the production of a swelling which reached so high as to cause pressure on the innominate artery. The coronary arteries were atheromatous.

Rupture of a coronary artery is a rare incident. The curious failure of the right pulse is attributed by the writer to pressure of the extravasated blood on the innominate artery, which was relieved when she turned on her left side.

LANCET, Sept. 10, p. 690.

A Pin in the Rectum for Thirty Years.

By W. DUTTON AKERS.

A man aged fifty-eight, a linendraper, suffered from rectal pain of a pricking nature, constant desire to defecate, and great pain in the process. The motions were small and streaked with blood. These symptoms had existed in varying intensity for thirty years. He had frequently sought medical aid, been treated with morphia suppositories and other local applications. Examination revealed external hæmorrhoids and considerable inflammation and induration of the mucus membrane covering the internal sphincter. Above, and at the right side of the internal sphincter the head and about half an inch of the body of a pin were felt, the head projecting upwards and somewhat across the lumen of the intestine. The writer very properly draws the moral of the necessity of examining the rectum in such cases. We may add that fish-bones have similarly been unexpectedly found. The patient could not account for the pin.

BRITISH MEDICAL JOURNAL, August 20.

ANNUAL MEETING OF THE ASSOCIATION.

The Use and Abuse of the Midwifery Forceps.

The discussion on this subject, as might have been expected, did not result in anything very definite, but there seems to have been a general opinion among the speakers that the forceps is used excessively. The assertion of Dr. Sinclair in his Presidential Address at the previous Montreal meeting, which caused so much sensation—that midwifery had become too surgical, and that the obstetricians were the providers of material for the gynecologists—was referred to by Dr. Milne Murray as an indictment of the present practice of midwifery. He laid down as a guiding general principle that an indication for the use of the forceps arose whenever the danger of interference became less than that of leaving the patient alone. Disastrous results followed their use in cases of undilated os. There was a form of undilated os not generally recognised which accounted for the occurrence of the greater number of cases of lacerated cervix. The os was soft and flabby, and apparently the size of the child's head. The forceps were easily applied, but with the uterine pain excited by the manipulation the os became spasmodically contracted round the head and forceps, and not more than half its previous size. He strongly advocated the axis traction forceps. Their advantages were security of grasp, absence of dangerous compression, ease of extraction, delicacy with which the proper axis can be ascertained and followed, safety of the soft parts, and the facility with which they produce or permit rotation. He thought that the practice of the French school—to apply the forceps to the biparietal diameter of the child's head wherever situated—was sounder than the British—to apply the forceps in the transverse diameter of the pelvis.

Dr. Arthur Macan pointed out that the ordinary forceps could and, indeed, ought to be used as an axis traction instrument. Traction in the direction of the handles was always wrong; traction by both hands, one at each end of the handles, drawing the latter in a series of parallel lines towards the chest of the operator was essential to axis traction.

Dr. Laphorn Smith, of Montreal, deprecated the too frequent use of the forceps. He impressed upon

his students, and he implored those who heard him, never to put on the forceps in a normal first labour unless it had been going on actively for twenty-four hours. If they would not do so they would not have to deplore so many fearful injuries.

THE BRITISH MEDICAL JOURNAL, August 20.

BRITISH MEDICAL ASSOCIATION.

Annual Meeting: Section of Obstetrics and Gynecology.

The Surgery of Pelvic Inflammation.

Dr. Cullingworth opened the discussion on this subject. He said that cases attended with suppuration required operation. In pelvic cellulitis the abscess should be evacuated without opening the peritoneum. In the majority of cases it pointed above Poupart's ligament, which indicated the site for incision. But if suppuration occurred near the pelvic glands, that is, behind the posterior parietal layer of pelvic peritoneum the abscess was too deep to point. Here the operation was more complicated, requiring an incision similar to that for tying the external iliac artery, followed by careful dissection beneath the uplifted peritoneum. More rarely pus collected between the bladder and cervix uteri, or behind the posterior vaginal wall. In these cases the opening must be made from the vagina.

In pelvic peritonitis, pus might form in Fallopian tube, ovary, or amongst peritoneal adhesions. The diagnosis of suppuration was difficult. After the subsidence of acute symptoms in a case of pelvic peritonitis, due to tubal inflammation, bimanual examination revealed a swelling in the posterior fossa of the pelvis on the affected side, extending sometimes into the pouch of Douglas. In a non-suppurative case the swelling was formed by a thickened and enlarged Fallopian tube fixed by adhesions. If, however, such a swelling was larger than would be accounted for by the pathological conditions described, and continued to increase in size in spite of rest and warm applications, pus was almost certainly present, and operation was indicated. Again, if during an attack of acute inflammation of the uterine appendages a tense globular cystic swelling were formed in the pouch of Douglas, bulging downwards into the vagina and backwards into the

rectum, the probabilities were strong that the swelling was an intraperitoneal abscess. Further, the recurrent attacks of pelvic peritonitis in a patient who had had acute salpingitis, and in whom there remained a quiescent swelling in the posterior part of the pelvis, were very suggestive of suppuration. In suppurative peritonitis operation should not be performed as a rule until the acute symptoms had subsided. But there were many exceptions. For example, a septic condition, or the formation of rapidly-increasing swelling in Douglas's pouch, or in the lower part of the abdomen.

The Etiology of "Return Cases" of Scarlatina.

Dr. C. K. Millard (*Brit. Med. Jour.*, Sept. 3, p. 614), at the annual meeting of the Association, read a valuable and well-reasoned paper on this subject, based on his experience as Medical Superintendent of the Birmingham City Hospital. Out of 4,810 scarlatina patients, in 158—3·4 per cent.—the return home was followed at intervals varying from a few days to six weeks by a fresh outbreak of scarlatina in the household, although the greatest care was taken on the discharge of patients from the hospital to diminish the risk of infection. The reasons why infection does not always occur directly on discharge from the hospital are—(1) domestic isolation; (2) recrudescence of infectivity (often manifested by recurrence or occurrence of a nasal or aural discharge); (3) slight degree of infectivity, which requires the closest repeated contact before the infection "takes"; (4) varying susceptibility of the same individual. Thus a patient admitted by mistake into a scarlet fever ward may develop the disease at any period. The average period of isolation of the infecting cases was 8·3 weeks—almost the same as the average period of all cases. Though thirteen weeks was a fairly maximum period of isolation, infection was carried in rare cases as late as sixteen weeks.

The condition of the infecting cases on discharge is important. As a rule patients showing any lesions at the end of six or seven weeks were detained, but sometimes the lesions were so chronic and unyielding that parents declined to have their children indefinitely detained. Desquamation (he refers to late desquamation of the feet only) was

present in 7 per cent. of the infecting cases, abnormal fauces in 3·1, adenitis in 2·1, sores and excoriations in 3·1, eruptions in 3·1, albuminuria in 0·6, otorrhœa in 2·2, rhinitis in 22·9, and no lesions in 58·2. It was evident that this late desquamation was no source of danger. Rhinitis undoubtedly was the most important factor in carrying infection; its proportion in infecting cases was four times as great as in non-infecting. Otorrhœa is undoubtedly infectious, but being more definite than rhinitis, it is easier to be sure of its presence and detain the cases. As a rule, cases of the latter were kept for at least thirteen weeks. Beyond this period the risk of infection is slight. Recrudescence of infectivity undoubtedly occurred: in thirty-three cases which went home quite well out of sixty infecting cases, two developed otorrhœa and ten rhinitis prior to the occurrence of the return case.

Dr. Millard concludes that we have no right to assume that the virus of scarlet fever has left the system because there is no visible manifestation of it. In nasal diphtheria Mr. J. C. Heaven has shown that the virus may persist for six months. Dr. Millard might have reinforced his arguments on this point by a general one—the doctrine of the “latency of disease germs”—which has only lately attracted attention, and by a special one—relapses in scarlatina.

BRITISH MEDICAL JOURNAL, Sept. 10.

ANNUAL MEETING OF THE ASSOCIATION.

The Ocular Phenomena in General Paralysis of the Insane.

By W. R. DAWSON, M.D., and D. F. RAMBAUT, M.D.

Observations were made on forty cases in the Richmond Asylum, Dublin. Paralysis of the external ocular muscles (ptosis and strabismus) existed in five cases. The pupils were unequal in ninety-two per cent. of the cases. As this condition is not uncommon in other forms of insanity, and not unknown in health, the writers agree with Siemerling in not considering it a symptom of the importance usually assigned to it. The size of the pupils was noted in twenty-three cases: eight had mydriasis in both eyes, and six myosis; three had myosis of one eye. In one case there was mydriasis of the right, and myosis of the left eye. In eighteen cases, therefore (78·2

per cent.), the pupils were of abnormal size. Two mydriatic and three myotic cases had reflex iridoplegia. As stated by Dr. Beevan Lewis, the sympathetic reflex was that which was most frequently impaired: it was lost in thirty-three cases, and diminished in five. But this symptom is of only negative value, for it was found in fourteen out of sixteen control cases. The consensual light reflex was absent or impaired in 67·5 per cent., the direct in 42·5. The Argyll-Robertson pupil was found only five times in one eye, and three times in both.

The fundus was examined in thirty cases; three showed advanced atrophy; five, optic neuritis.

Dr. John Macpherson had found that the ocular symptoms were not always constant in the individual. A patient might show inequality, irregularity of outline, contraction, or dilatation of pupils at one time, and not at another. Again, the reaction to light and accommodation might be absent, or the Argyll-Robertson pupils might be present for weeks, and these reactions subsequently be found normal.

Noma of the Ear.

By G. MUNRO SMITH, L.R.C.P., M.R.C.S.

A fairly nourished but rather anæmic child was admitted to hospital with a history of occasional discharge from the left ear and eczema. The whole of the left auricle was swollen and red, and pus was exuding from the meatus; the cheek was œdematous. There was a small clean cut ulcer in the fossa of the antihelix, covered with a greenish-grey, slightly adherent, slough. Improvement occurred under antiseptics, but at the end of ten days the auricle began to swell. The ulcer spread rapidly; it was scraped, and carbolic acid was applied. The ulcer improved, but in a few days the disease made a fresh start, and its ravages could only be temporarily checked by cutting away the necrosed tissues, and applying strong antiseptics. The condyle of the jaw became exposed, symptoms of meningitis appeared, and the child died six weeks after admission.

At the necropsy, the auricle was represented by a small crescentic mass. A large irregular cavity with sharply excavated sides, exposed the condyle of the jaw and the temporal bone. The vessels of the vertex of the brain were much congested, and

there was thrombosis of the lateral and superior longitudinal sinuses.

The clinical features were fairly typical of noma, but there was an almost complete absence of the usual black slough. The situation was very unusual, the writer could find no record in which the external ear was primarily attacked.

A bacteriological examination was made, and the small bacillus with rounded ends, described by Schimmelbusch in connection with noma, was found.

MEDICAL PRESS, August 31, p. 209.

The Sealing of Laparotomy Wounds

By E. STANMORE BISHOP, F.R.C.S.

Drainage tubes after laparotomy encourage supuration. Omentum and intestine are caught in the openings of the tubes, which they plug, whilst they themselves become injured. In one or two recorded cases fæcal fistulæ have been produced by pressure of the tube. Taking 100 cases of similar pelvic inflammatory conditions, untoward results followed in 20 per cent. of undrained, and in 54 per cent. of drained operations. Suppuration of the abdominal wound existed in 14 per cent. of undrained, and in 24 per cent. of drained cases. Deaths took place in 6 per cent. of undrained, and 13 of drained cases. Ventral hernia also is more liable to occur in drained cases. But not only is drainage harmful—it is useless. The fluids which are exuded after operation if uncontaminated are harmless. Our efforts should be directed towards antisepsis. Wegner showed that the peritoneal surface was equivalent in area to the skin, and capable of absorbing in one hour 3.8 per cent. of the whole body weight. The prolonged contact of the tube irritates the peritoneum. He often found an encapsulated collection of infected matter within half a centimètre of the drainage track. Drs. Miller and Clark examined sixteen gauze drains used after laparotomies. In every instance cocci were found, although the fluids present at the operation were aseptic. It used to be considered that the escape of pus from, say, a pyosalpinx into the abdominal cavity necessitated drainage, but it has been found that, in thirty-four out of forty-two cases, no bacteria were present in the pus. There are rare cases in which the intestine

is much damaged, and in which it is impossible to feel that the bowel may not give way. Here opinion is divided, and a definite rule cannot be laid down.

The question of abdominal drainage incidentally involves the question of wound drainage in general, and the same arguments apply. If at the moment of operation the wound could be sealed with an air-tight material, which would remain so until healing was complete, primary union might be reckoned upon. With the new dressing, cellordin, first described by Dr. Mackenzie (*B.M.J.*, February 1, 1896) a transparent closely adherent film can be applied which has the advantage of contracting. Mr. Bishop reports three cases out of a large number to illustrate its advantages. They are ovariectomy, removal of appendix, and suprapubic lithotomy. Union by first intention was obtained in all under one dressing. If perfect asepsis has not been secured the transparency of the dressing enables the place where it is faulty to be seen.

The Cerebral Cortical Cell under the influence of Poisonous Doses of Potassium Bromide.

Dr. Hamilton K. Wright (*Brain*, Part II., p. 186) describes the following case:—

A man, aged twenty-six, the subject of epilepsy, took 160 grains of potassium bromide three times a day as a result of an error in dispensing. On the second or third day he became heavy and stupid. The stupor gradually increased, muscular weakness supervened. On the 17th day there was difficulty of deglutition, and on the 18th he failed to recognise his friends, and had incontinence of urine. He became comatose, his temperature rose to 101.4 deg., bronchitis and pneumonia developed, and he died on the 22nd day.

A necropsy showed slight œdematous effusion over the whole cerebral cortex, and noticeable capillary distension in the frontal and parietal pia mater. Microscopical examination showed degeneration of the cortical cells and varicose swellings of the dendrons. Experiments on rabbits confirmed the view that these changes were the result of poisoning by potassium bromide. This case seems to us important practically, for it tends to show, what has been questioned, that prolonged dosing with potassium bromide—for example, in epilepsy—may have injurious effects on the brain.

PRACTITIONER, September.

The Treatment of Chronic Gouty and Rheumatic Joint Affections.

By Dr. F. LEVISON, Copenhagen.

Edison showed that with the help of the constant current lithium could be made to pass through an animal membrane in considerable quantity. If a man placed his right-hand in a 2 per cent. solution of lithium, and his left in a dilute solution of sodium chloride, and if the positive pole were placed in the former and the negative in the latter, lithium could be easily introduced through the skin. Lastly, by treating the hands of a gouty man four times a day with a current of 20 milliampères, Edison produced considerable improvement. Labatut showed that by this method no inconsiderable quantities of certain substances can be introduced into the body, and that acid, and acid-forming substances enter at the negative pole, and diffuse themselves through the organism towards the positive; whereas basic substances enter at the positive pole, and diffuse towards the negative.

Dr. Levison has treated a number of cases of chronic gout by this method with decided success. Many patients whose disease dated back ten to twenty years, and who were unable to use the affected limbs, showed conspicuous improvement. Tophi became smaller and softer, but did not wholly disappear. But the spindle-shaped enlargement of the fingers sometimes seen in gouty persons was only in part removed, although the pain was relieved and the mobility of the joints was restored. The best results were always obtained where the diagnosis of gout could be made with certainty; these were far better than where other causes for the joint disease could be assigned.

In arthritis deformans the joints after a time appeared to remain somewhat more movable, but the results were not conspicuous. In this disease warmth was the best treatment, and the dry air bath was the best method. He used a simple apparatus which can be obtained from Messrs Allen & Sons, London. The heat is developed by a lamp placed under a wooden chair, upon which the patient sits naked, surrounded by a cape of unflammable material, which is held out by a stand from the body and the chair. A temperature of 140° F. can be so produced, and the patient,

whose head is outside the heated air, can readily endure twenty-five or thirty minutes in the bath. Profuse sweating is caused, which can be maintained by packing in blankets after the patient is put to bed. If he is so invalided that he can with difficulty sit, the hot air can be applied in bed. From the local hot-air baths (recommended by Sibley and others) Dr. Levison has also obtained excellent results. A lady, aged 32, had stiffness and pain in the knees for six years, which disappeared after twenty-six days treatment by hot air and massage.

Uranium Nitrate in Glycosuria and Diabetes.

By C. H. BOND, M.D.

The writer's experience at the Banstead Asylum, confirms Dr. Samuel West's conclusions as to the value of this remedy. He gave it in doses of gr. iii., gradually increased, twice daily after food, never in less than an ounce of water. In glycosuria without other symptoms of diabetes, the urine could easily be entirely freed from sugar, and kept so as long as the drug was continued. In one case of diabetes an actual cure appears to have been produced. In all instances the results were obtained without the anti-diabetic diet. The case referred to was this: A man subject of melancholia, had diabetes for eight years. He was excreting daily 4,000 grains of sugar in 100 ounces of urine. Dieting and codeia were tried, but the sugar never fell below 340 grains. Nitrate of uranium was given in doses of 3 grains twice daily, increased to 6 at the end of a week. At the end of three weeks there was only a trace of sugar, and the urine was reduced to 70 ounces. All dietetic restrictions were withdrawn, and he continued to take 6 grains of uranium thrice daily for two months, during which the sugar varied from a trace to 100 grains occasionally. Ten grains three times a day entirely removed the sugar, and the urine fell to a normal amount, with a specific gravity of 1018 instead of 1034, the thirst ceased, and he greatly improved in every respect. At the end of another two months the dose was reduced to 6 grains thrice daily, which he took for seven months. Five months later he was discharged mentally and physically cured. His melancholy afterwards returned, but the glycosuria

did not re-appear. This appears to be the greatest success yet recorded of uranium. In three other cases of diabetes the thirst and genital irritation were relieved, but the glycosuria was not reduced more than 50 per cent.

HUTCHINSON'S ARCHIVES OF SURGERY, July.

The Avoidance of Splints in Colles's Fracture.

Mr. Hutchinson formally encouraged his house-surgeons at the London Hospital to treat many cases of Colles's fracture without splints. His instructions were never to put on splints unless there was displacement which could be removed by extension, and which returned when extension ceased. In such cases—a very small proportion only—splints are indicated, but they ought not to be kept on long. If the routine treatment by splints were laid aside it would be greatly to the advantage of patients and the credit of surgeons. In many cases treated in the orthodox way the wrist and fingers become stiffened, and the hand often becomes painful and useless. Nineteen-twentieths of these cases would have done well and escaped stiffening if the wrist had been kept between two cushion-pads for a fortnight. The public, as well as the profession, seemingly think that there is a necessary connection between a fracture and a splint. If one reflects on the real condition present in Colles's fracture, the truth of these remarks will be evident. In many there is no displacement whatever, and no movements of the patient could produce any. In others there is displacement of the carpal fragment backwards and to the radial side. If this is present, and can be removed by extension, and returns when extension is remitted, then a splint is necessary, but not otherwise.

Xanthoma as a Symptom.

To the zoologist some of the most interesting animals are those which appear to afford connecting links between species, or which indicate alliances between different genera. It is the same in clinical pathology, although here the lines of distinction between different species are much less definite. The factors of causation are more easy of combination and hybrids are more easily produced.

In the Xanthoma group are four types. (1) The common xanthoma of the eyelids which often indicates liability to sick headaches from liver-disturbance (*X. palpebrarum*). (2) A general eruption of sudden onset and capable of spontaneous disappearance, which occurs to the diabetic, and also sometimes to those who have no glycosuria but are severely bilious (*X. diabetorum*). (3) A form which is consequent on persisting jaundice and indicative of organic hepatic disease (*X. icterorum*)—here plates and lines of Xanthoma form in various parts, notably in the flexures of the fingers. (4) A congenital and family form, in which, without any disturbance of health, children present Xanthoma spots and patches on various parts, more especially on those prone to be affected with psoriasis (*X. congenitalis*). The bond which allies all forms is the circulation of the bile-acids in the blood as a primary cause, and this receives its modifications from other conditions, such as inheritance or proneness to psoriasis and the degree of persistence of liver disturbance. We meet every now and then with mixed cases, of which the following is an example.

A woman, aged twenty-three, had diffuse pigmentation of the eyelids and ill-defined patches of xanthoma, not in the usual position above and below the inner canthus, but on the middle of the lid. On the tip of the lobe of each ear was a patch. There was gout in the family and liability to severe bilious attacks. The patient had suffered from headaches, often so severe as to make her go to bed, and always attended by dark pigmentation around the eyes. The xanthoma on the eyelids had first been noticed about ten years ago, and the patches on the ears soon followed. Two or three years later she had an attack of deep jaundice.

The noteworthy features in this case are :—(1) The early development of the *X. palpebrarum*; (2) the unusual position; (3) the extreme pigmentation of the eyelids; (4) the patches on the ears; (5) the prolonged attack of jaundice in a patient the subject of *X. palpebrarum*.

HUTCHINSON ARCHIVES, July.

Abortive Herpes Zoster.

The dermatitis of Herpes must be regarded as a sort of complication of neuritis. The latter

is the essential part. Very probably many cases of neuritis, of what we may call the herpetic type, do not proceed so far as to produce vesiculation over the end-organs of the nerves in the skin. The latter being absent, there would be no "herpes" in the ordinary sense. Such cases may be called abortive herpes. Thus many forms of unexplained local pain may be herpetic. Mr. Hutchinson relates the following cases :—

ABORTIVE SYMMETRICAL ZOSTER FROM ARSENIC.—A woman, aged twenty-one, had a very slight, quite abortive eruption on both sides, curving round about the hips like herpes. She had taken arsenic, m. vi., for one month. The spots had been present a few days, and have caused no pain. No vesicles had formed.

DOUBLE AND MULTIPLE ZOSTER ARRESTED AT THE PAPULAR STAGE.—No irritation. The patient had large groups of papules arranged like zoster; there were no vesicles.

HERPES OF THE CERVICAL PLEXUS ABORTIVE ON THE PERIPHERAL REGIONS.—The spots covered all the sides of the neck and mastoid region. The groups outlying the legitimate district (as the writer had often seen before) were everywhere faintly marked. Some of them were scarcely vesicular, merely abortive papules.

THE EDINBURGH MEDICAL JOURNAL, September.

Movable Kidney.

By C. W. SUCKLING, M.D.

Dr. Suckling makes it a rule to thoroughly examine every patient—not only the part complained of, but all organs. In the case of women, he always insists on the corset being removed and of an examination of the abdomen. In this way he has come across hundreds of cases of movable kidney.

What is meant by movable kidney?—A kidney is movable which can be grasped by the hand, felt below the ribs, and made to slip up by the hand; the term dropped or dislocated is better than movable.

Why is movable kidney so frequently overlooked?—From want of knowledge of its frequency, importance, and of the proper mode of examination.

Frequency.—In his private cases, 42 out of 100 women had dropped kidney, and out of 100 men six.

Diagnosis.—The patient should be lying down. To feel the right kidney the right hand should be placed on the abdomen, the thumb being under the last rib at the back, and the fingers in front below the costal margin. The kidney may be felt with slight pressure to be down; if not, when the patient draws a deep breath, the kidney will slip into the fingers, and can be slipped back easily. A common mistake is to palpate the abdomen with the palm of the hand. This simply pushes the kidney in front of the hand. When the patient sits or stands the kidney comes down still more; and before concluding that the kidney is not movable, examination should be made in one of these positions. In examining the left kidney the left arm should be placed round the body, the physician standing on the right of the patient, the fingers being placed under the last rib, the right hand should be placed under the left costal margin; on drawing the breath or on sitting or standing, the kidney, if movable, will be felt between the fingers, and can be made to slip up in a most characteristic way.

Symptoms.—There may be none; but in the majority of cases there is marked ill-health. In the case of the right kidney there is rarely pain, but on exertion an uneasy feeling in the back of the right side. In the case of the left kidney, pain is the most prominent symptom and is very severe. The pain disappears when the patient lies down, and comes on when she sits, stands, or walks. The pain is under the left costal margin and runs round the left side. A frequent symptom of movable kidney is inability to walk, or to stand, or even to sit for long. Movable right kidney may disturb the liver and produce aching under the right shoulder, tenderness of the liver, bile in the urine, and attacks resembling biliary colic. Other symptoms of movable kidney are palpitation of the heart, vertigo, enlarged spleen, dyspepsia, albuminuria, diarrhoea, constipation, and colic.

Treatment.—Having found the ordinary belts useless, Dr. Suckling has devised a belt (made by Messrs. Salt) which will keep the kidney in its place. The essential feature is a strap placed outside the belt, which enables a pad to be driven in. The belt should be put on lying down, when

the kidney usually drops into its place. If it does not, the patient should press the abdomen gently upwards with her hand before putting on the belt. The belt not only removes the symptoms, but in some cases cures. Operation will be rarely necessary.

Persistent Priapism from Thrombosis of the Corpora Cavernosa.

By F. PARKES WEBER, M.D., F.R.C.P.

A sallow-looking German baker, aged 46, was admitted to hospital. Two days previously he awoke at 4 a.m. with an erection of the penis (an unusual occurrence), which had persisted. It was not accompanied by any sexual desire. He had a chancre twelve years ago. There was no history of gout or saturnism. He had had no sexual intercourse during the preceding two weeks. The penis was erect, somewhat hard, and tender. The corpora cavernosa were alone concerned in the erection; they felt as if they had been injected with plaster of Paris. The corpus spongiosum, glans penis, and vena dorsalis were soft. The blood was normal.

The treatment consisted of rest in bed, prevention of pressure by the bed-clothes, lead lotion, and iodide of potassium (gr. x. t.d.s.). On the twenty-fourth day improvement was noticed; the proximal portions of the corpora cavernosa were softer. On the thirty-eighth day the whole penis was flexible, but the corpora cavernosa were somewhat hard.

The priapism, obviously, was not of nervous origin, for the corpora cavernosa only were involved. Moreover, in nervous cases an intermittent priapism may be excited by the least irritation—movements of the bed-clothes, passing of a catheter. The facts, therefore, pointed to thrombosis as the cause. The thrombosis might have been spontaneous and due to the patient's somewhat cachectic condition, or it might have been determined by some slight vascular lesion during erection. Gout has been the cause in some cases. This thrombotic form of persistent priapism has been observed several times in leukæmia, where the tendency of the blood to coagulate is increased.

Dr. A. H. Ward (*Lancet*, 1897, I., p. 1,143) has published a case of this kind, and tabulated twelve other cases of persistent priapism, lasting for periods varying from nineteen days to seven weeks. Of these one was complicated with leukæmia, one

had enlarged spleen from previous intermittent fever, one had hæmoptysis, and one was associated with gout. In four the condition was started by sexual intercourse, in one by straining at stool, and in one by accident. In some cases of persistent priapism, fluctuation has been felt. Suppuration might therefore be diagnosed, and an incision made. But this in two cases seemed to have been due to softening of clot, for resolution occurred.

GLASGOW MEDICAL JOURNAL, September.

Painful Subcutaneous Tumour in the midst of Nævroid Tissue.

By DR. RUTHERFORD.

A man, aged fifty, complained of a painful and exquisitely tender spot on the abdominal wall. The symptoms had existed for fourteen years, but after the first year they disappeared for eighteen months.

About $1\frac{1}{2}$ in. to the left of the umbilicus, and below its middle, was a nodule the size of a pea. It was so tender that the patient was in the habit of protecting it with his hands as he walked about. It was cut down upon, and found to be a subcutaneous nodule in the midst of nævroid tissue. Microscopically, it showed numerous minute blood-vessels in a mass of large clear-bodied cells, with single nuclei and well-defined walls presenting a tessellated appearance. No nerve-elements could be recognised.

Virchow divided painful subcutaneous tumours into myomata, angiomata, and neuromata. The only other tumour of the kind which Dr. Rutherford had examined seemed to be a myoma. It was from the leg of a young woman, and showed itself in her first pregnancy, and disappeared to reappear in subsequent pregnancies. He thought that the tendency to venous engorgement of the lower limbs in pregnancy explained this.

Surgical Treatment of Acute Rheumatism.

By JOHN O'CONOR, M.A., M.D., Buenos Ayres.

The writer relates two cases treated by this method which he has for some time advocated.

A man, aged forty, was admitted to hospital with furred tongue, profuse sweating, and a temperature of $101\cdot4$ deg. There was intense pain in

the left ankle, right knee, and left elbow. There was considerable peri-arthritis about the ankle, the knee and elbow were swollen, tender, and immobile. Twenty grains of salicylate of soda were given every two hours. In two days there was no improvement. The left ankle joint was opened by a small incision parallel to the inner border of the external malleolus; only synovial fluid was found. Multiple incisions were then made through the swollen and inflamed periarticular structures, and the cellular tissue was freely opened up, the capsule was extensively exposed, and the tendon sheaths were incised. The wounds were irrigated and packed with perchloride gauze. The knee was opened, and six ounces of green, turbid, flocculent, almost purulent, serum was removed. Flakes were detached from recesses, and removed by irrigation, and a gauze drain was inserted. The elbow was similarly treated. After the operation the pains disappeared. He moved his elbow normally on the second day, ankle on the third, and knee on the sixth. The temperature fell to normal on the third morning. On the tenth day (Christmas day) he partook of a full meal; he was discharged cured on the twenty-sixth day.

The second case was a man aged forty-three, who had all the characteristic symptoms of rheumatic fever. Both wrists were opened and nothing abnormal was found, the inflamed surrounding structures were then opened up, irrigated, and drained. The left knee joint was similarly treated. The case progressed like the previous one.

Dr. O'Connor concludes that acute rheumatism is an acute infective arthritis, and should be combated by operative measures. We may add that several French observers—Achalmé, Thirloix, Triboulet, and Cuyon—claim to have observed a specific microbe.

Dr. O'Connor's observations bring one fact to light—that the joint-swellings in acute rheumatism may be not articular but periarticular.

GLASGOW MEDICAL JOURNAL, August.

The Early Symptoms of Pressure upon the Vagus and Recurrent Laryngeal Nerves.

By DAVID NEWMAN, M.D.

Sometimes the earliest symptoms of interference with the innervation of the larynx by the pressure of an aneurysm or mediastinal tumour within the

thorax is sudden and paroxysmal dyspnoea accompanied by laryngeal stridor. The stridor is usually inspiratory, rarely expiratory. Death may result from laryngeal suffocation. Laryngoscopic examination, not infrequently impossible during the attacks, may yield negative results in the intervals. But this negative fact is very important. For, if there is, in a patient passed middle life, a total absence of any lesion of the mucous membrane, and if no condition can be discovered which may physically impede the movements of the vocal cord, and if there is no evidence of any central nervous lesion or of pulmonary disease, the presumption is strongly in favour of aneurysm or mediastinal tumour. But cases are very seldom seen at this early stage.

The cough is characteristic and may lead the trained observer to suspect the nature of the malady causing it. Its chief features are hoarseness and imperfection. It is essentially a paralytic phenomenon; the glottis is not completely closed. Professor Gardiner has long taught the importance of imperfect cough; he was familiar with it long previous to the use of the laryngoscope.

At a later stage paralysis occurs, usually of one recurrent laryngeal nerve. The speaking voice may be but little altered or it may be impure.

BRISTOL MEDICO-CHIRURGICAL JOURNAL.
June 1898.

Occipital Presentations.

By J. G. SWAYNE, M.D.

Occipital presentations are rare, and have received but little notice. The following case is of more than ordinary interest:—

A primipara had been in tedious labour, with inefficient pains nineteen hours. The os was soft and the size of a crown, the membranes were entire, and the head was presenting. The posterior fontanelle could be felt in front of the centre of the os uteri, and a bony prominence (supposed to be the occipital protuberance) a little to the left of and behind the symphysis pubis. The presentation was, in fact, the ordinary one modified by extreme flexion of the head. After waiting a few hours until the os was more dilated the forceps were applied. An examination of the pelvic cavity, made with both hands, showed that it was not very capacious, especially in its antero-posterior

diameter. This accounted for an exaggeration of the movement of flexion, which caused such an elongation of the occipito-mental diameter of the head that, although the presenting part, the posterior fontanelle, was low in the pelvis, the ears were too high to be reached. They could not, therefore, be used as guide in applying the forceps. Simpson's long forceps were first used without avail. The short forceps were then tried, but a good grasp of the transverse diameter could not be secured, owing to the great amount of compression and moulding which that part had undergone. After a time the occiput was brought down, and the child delivered. It was a large boy, and weighed 9 lb. Respiration could not be established. The "caput succedaneum" covering the posterior fontanelle was the largest the writer had ever seen.

Occipital presentations are so rare that Dr. Swayne never met with one from 1838, when he began midwifery practice, until 1885. This presentation is due to extreme flexion of the head, produced by slightly contracted pelvis. The head enters the pelvis strongly flexed with sub-occipito-parietal plane in the brim. It is driven in like a wedge, and flattened in width and depth, and elongated in the fronto-occipital direction. The mistake has been made of supposing that the difficulty is the effect of the presentation, whereas it is the cause. The diagnosis is made by noticing that the posterior fontanelle occupies the centre of the uterine orifice, whilst the anterior is difficult to reach if it is in front, and impossible if behind. The head also presents very much flexed. Contraction of the pelvic cavity prevents extension of the head. In Dr. Swayne's case the more the head was forced down the more resistance it encountered. Owing to this the moulding process was extreme, and the elongation of the occipito-mental diameter was such that it exceeded the average length by at least two inches. The head thus becomes wedge-shaped and difficult to grasp with the forceps.

The Treatment of Graves's Disease by Schott Baths and the Weir-Mitchell System.

Dr. W. M. Semple relates a case in which, after the failure of most of the usual remedies, this method proved successful. Skimmed milk was given in large quantities. The first Schott bath

was a pronounced success. It was made weak—twenty gallons of water, one pound of common salt, and four ounces of chloride of calcium. The temperature was 95 deg., and the duration six minutes.

Isolation in Diphtheria.

The bacilli of diphtheria may persist in the throat for long periods after recovery from the disease; the patient may therefore be a source of infection. Dr. B. Rogers mentions some outbreaks of diphtheria in hospital which he supposes were produced in this way. Abel has recorded a case in which for sixty-five days after the disappearance of the membrane the bacillus could be cultivated, and Dr. Macgregor gives a case in which active bacilli were found in December in the throat of a boy aged six months, the attack of diphtheria having been recovered from in July; and Schäfer cites cases in which they were found seven and a-half months after the attack. Dr. Rogers mentions a case where the bacilli were found sixty-eight days after an attack. He concludes that, instead of allowing patients to mix with other children at the end of a month from the beginning of the illness, no case should be allowed to mix with healthy persons until bacteriological examination has shown the throat and nose to be free from bacilli.

DUBLIN JOUR. OF MED. SCIENCE, August

The Disuse of the Bed-pan in Typhoid Fever.

H. C. Drury, M.D., F.R.C.P.I., observes that there is no doubt that to many people the use of the bed-pan is exceedingly irksome.

He remembers one doctor that he attended who, though he had not enteric fever, had diarrhoea, and such extreme weakness that we feared his sitting up. Every art and persuasion was used to get him to use the bed-pan; he did try a few times, but, after that, persuasion was useless; he would always get out of bed to the night-chair as long as he had strength to do so.

The bed-pan is seldom used, even in typhoid fever, in Cork-street Hospital. There is a night chair beside every bed, and as long as the patient is able to get up to this he is allowed to do so. The nurse gives him assistance and covers him up. Only when unable to get out of bed is the bed-pan

used; then it is found in many cases to be unnecessary, as by that time the patient generally passes all evacuations unconsciously.

The arguments in favour of this practice are :—

1. Less annoyance to the patient.
2. More complete evacuation of the bowel, and therefore less frequent disturbance.
3. The more natural position causes less straining, and therefore really less risk of either hæmorrhage or perforation.

A weak patient cannot fall off the chair on account of the strong high arms, which give him comfortable support while he sits up.

It will, of course, be objected that this is a ready way of courting disaster, either by hæmorrhage, perforation, or syncope. Dr. Drury states that this has not been his experience.

The Prolongation of Nitrous Oxide Anæsthesia for Dental Operations by Means of a Mouth-tube, and Closure of the Nares.

Dr. W. J. McCardie and Mr. W. T. Madin (*Jour. of Brit. Dent. Assoc.*, September, p. 660) have been using this method as a routine practice at the Dental Hospital, Birmingham, in all cases requiring prolonged anæsthesia. The gas is first given in the usual way, then the face-piece is rapidly changed for the mouth-tube and nose-clip (or the nose is compressed by the fingers). A stream of gas is allowed to flow into the mouth continuously or intermittently. The guide to the administrator is the colour of the face. The lips should be slightly blue, and the breathing quiet, or quietly snoring. In one case anæsthesia was prolonged to 9 min. 55 sec. The closure of nares helps to prolong the anæsthesia and minimise the amount of gas required.

Gangrenous Stomatitis: Septicæmia: Death.

Mr. Cuthbert Lockyer (*Jour. of the Brit. Dent. Assoc.*, August) records the following case under the care of Mr. Stanley Boyd at Charing Cross Hospital:—A boy, aged 18, removed three carious roots from the left side of his maxilla with a sharpened wooden penholder, used as an elevator. Four days later the face began to swell, and on the next day he noticed that the outside of the alveolus was black. The pain was so severe that sleep was

impossible. At the end of a week, when admitted, there was a blackish grey, ashy slough on the left side of the palate, where the stump had been removed. The adjacent teeth were very loose, and pus welled up when they were touched. Surrounding the slough was a large area of inflamed mucous membrane. The sub-maxillary and deep cervical lymphatic glands were swollen. Under anæsthesia the slough was scraped away, the loose teeth were removed, and the surface painted with carbolic acid. Antiseptic mouth washes were used, but the slough rapidly extended over the whole left half of the palate. A second operation was performed and Paquelin's cautery was applied. The patient became worse: purpura, hæmaturia, abdominal pain, and enlargement of the liver, appeared. The staphylococcus pyogenes aureus was cultivated from the blood. He died on the 17th day after admission.

A necropsy showed necrosis of the left half of the hard palate, the antrum filled with slough, the lungs œdematous and pneumonic in one part, the liver and spleen enlarged.

THE AMERICAN JOURNAL OF MEDICAL SCIENCES,
August, 1898.

The Treatment of Malignant Tumours by Mixed Toxins.

Dr. G. R. Fowler contributes an exhaustive paper on this subject which contains the latest results of Dr. Coley, who introduced this treatment of subcutaneous injection of the toxins of erysipelas and of the bacillus prodigiosus. Dr. Coley has treated 140 cases of sarcoma; in seventeen the growth completely disappeared. Of the cases which haven't relapsed, one has exceeded the four-year limit, one the three-year limit, and two the two-year limit. Of those that recurred, the longest time of immunity was three and a-quarter years, and the shortest was six months. In one case of recurrence the tumour disappeared a second time under the toxins. Coley advises that in carrying out his treatment, a small dose—one-quarter of a minim—should be given at first, which is to be increased at each administration; for the effect on different individuals varies, and with larger doses collapse may be produced, which has proved fatal in some cases. All his cases were treated by interstitial injections into the tumour. In carcinoma

Coley has never advised this treatment, except tentatively. The majority of the cases show very little, if any, improvement. But in some a marked inhibitory action and diminution in size was evident, and in one (epithelioma of the mouth) the growth disappeared and had not recurred three years afterwards.

THE AMERICAN JOURNAL OF OBSTETRICS, &C,
July.

The Treatment of Puerperal Sepsis.

Dr. Paul Mundé's Presidential Address to the American Gynecological Association on Puerperal Sepsis is of value, not because it contains anything very novel, but because it is a statement of the practice of an experienced authority. He observes that for the formation of a correct diagnosis the genital organs should be digitally examined; first for lesions of the external organs, the vagina, and cervix; then to determine whether the uterus is empty or whether it contains some septic focus—portions of placenta, membranes, or coagula, or whether the endometrium presents the peculiar, spongy, thickened, and furrowed feel, of puerperal septic endometritis. If thought advisable, a specular examination may be made of the vagina and cervix, which may reveal lacerations presenting a yellow or brownish gangrenous appearance.

All substances which may be a source of infection should be removed from the endometrium, either with the finger or with the large long blunt curette which the speaker had made sixteen years ago. When emptied the uterus should be irrigated with a mild solution of permanganate of potassium, or, if the substances removed are offensive, with Marchand's solution of peroxide of hydrogen diluted one-half. He seldom employs perchloride of mercury, and never stronger than 1 in 10,000. He does not approve of iodoform pencils; they simply mask the odour and character of the discharges. But he has seen good results from packing the endometrium with iodoform gauze to induce contraction of the uterus. In bad cases of septic endometritis with a great deal of inflammatory hypertrophy of the uterine wall, he is not in favour of using the curette, either dull or sharp. He only uses the sharp curette to the puerperal endometrium when he fails to remove the substance

which produces the sepsis. Curetting of a septic endometrium does more harm than good; it opens fresh channels for infection. It is far better to apply a solution of chloride of zinc (20 to 30 per cent.), or pure tincture of iodine, or iodized phenol through a cylindrical speculum, and then to wash away loose *débris* with sterilized water, and pack the cavity with iodoform gauze for forty-eight hours or longer, provided there is no chill or rise of temperature. Intrauterine irrigation will then be necessary for some days. If the uterus is entirely empty, and if there is nothing in it that can produce sepsis, even though there be high temperature and pulse, it is useless (as is often done) to continue irrigation. Infected vaginal or perineal wounds should be touched with a saturated solution of permanganate of potassium, or a 25 per cent. solution of chloride of zinc.

Medicinal treatment is unsatisfactory. Large doses of quinine only influence the temperature momentarily; they have no influence on septic germs. The coal tar derivatives—antipyrin, phenacetin, &c.—reduce temperature only temporarily, and are beneficial only in rendering the patient for the time more comfortable. But they mask the fever and depress the heart. The influence on the heart may be combated by caffeine. Dr. Mundé gives phenacetin in 3 to 5-grain doses, combined with caffeine. He recommends anti-streptococcic serum; having used it in three desperate cases which failed to respond to other treatment. From three to six injections were given at intervals of from four to twelve hours.

AMERICAN JOURNAL OF OBSTETRICS, July.

The Surgical Treatment of Irreducible Retroflexion of the Pregnant Uterus.

The treatment of retroflexion of the pregnant uterus with incarceration is to replace the uterus, or, if this is impossible, to empty it. Dr. Matthew Mann claims that recent experiences in abdominal surgery should alter the second alternative: the uterus should be replaced by laparotomy. If the uterus be so large as to completely fill the pelvis, replacement through the vagina will fail, not because the uterus is too large to be forced through the pelvic brim, but because, when pushed up, nothing can enter from above to replace it, and the moment pressure is withdrawn from below,

atmospheric pressure forces it again into its old position. Also, adhesions may be an insuperable bar to reposition.

A multipara, four months' pregnant, suffered from great pelvic pain, and inability to empty the rectum and bladder. The pelvis was filled by the retroflexed uterus, which could not be replaced even in the knee position under an anæsthetic. Laparotomy was performed and by introducing the hand behind the uterus, the fundus was with difficulty got out of the pelvis. She made a prompt recovery. Dr. Mann operated on a second case also successfully. The only other recorded case of this operation is one reported by Dr. Murdoch Cameron (*Brit. Med. Jour.*, vol. xi., 1896, p. 1,277).

JOURNAL OF CUTANEOUS AND GENITO-URINARY
DISEASES, July, 1898.

The Treatment of Acute Gonorrhœa.

Dr. G. K. Swinburne has treated fully 1,000 cases by Janet's method of irrigation with solution of permanganate of potassium. Its value is shown by the fact that in only one case epididymitis developed during the treatment. But this complication occurred in a number of cases treated by his assistants, which he attributes to their method. They filled the urethra with the fluid, then closed the urethra with the nozzle, and held it there until the resistance of the sphincters was overcome, and they did this in cases where irrigation of the posterior urethra was unnecessary. He always adopts the following plan.—The patient is first habituated to having his anterior urethra irrigated. When he finds that he is not hurt he will unconsciously relax his muscles, and often without his knowledge some of the fluid enters his bladder. Soon he learns to relax the muscles by trying to micturate. In this way the fluid enters the bladder without using violence. The patient should be seated comfortably on the edge of a chair, and leaning backwards. The bladder can often be filled rapidly, even when the reservoir is only at height of $2\frac{1}{2}$ -feet. Dr. Swinburne makes it a point to avoid using force. The strength of the solution seldom exceeds 1 in 2,000 for the anterior, and 1 in 4,000 for the posterior urethra. He has lately added to this method the use, to the anterior urethra only, of argonin in 10 per cent. solution.

It is injected by an ordinary syringe, and held in the urethra for five to ten minutes. He always follows the course of the disease by microscopical examinations, continues the treatment several days after gonococci have disappeared, and asks the patient to return in a month for examination. This combined treatment has proved more efficacious than either method singly.

Largin in the Treatment of Gonorrhœa.

Lately a number of preparations of silver combined with albumen have been used with success as substitutes for silver nitrate, especially in the treatment of gonorrhœa. Such are argonin, protargol, and the latest, called largin. The last-named is a combination of silver with paranucleoproteid. All these have the advantages of being comparatively non-irritating and highly bactericidal. Kornfeld (*Wiener Med. Presse*, August 14, 1898) gives the results obtained with largin (1) in the laboratory by Pezzoli, and (2) clinically by himself. Largin contains a constant percentage of 11.10 silver. It is a greyish-white powder, soluble in water, but insoluble in alcohol, ether, &c. Aqueous solutions are not precipitated by chlorides, alcohol, or albumen. It is not decomposed readily. Its bactericidal power is greater than that of other albuminous silver preparations (1 in 4,000 kills the gonococci in ten minutes), and it penetrates more deeply into dead organic matter. Owing to its non-irritating properties, it is possible to carry out Neisser's plan of prolonged injections at once, which cannot be done with astringents, such as permanganate of potash or silver nitrate. Kornfeld uses $\frac{1}{4}$ per cent. of largin, gradually increasing the strength of the solution to $1\frac{1}{2}$ per cent. The injections are made three times a day, and are kept in the urethra five to ten minutes every morning and midday, in the evening fifteen to thirty minutes. Kornfeld has treated twenty-nine cases with the following results. (a) In recent acute anterior urethritis the gonococci soon disappear from the discharge (in about eight days). Its great advantage seems to be that when the treatment is begun early it prevents the inflammation spreading backwards to the posterior urethra and bladder; in this respect it acts with greater certainty than protargol. (b) In sub-acute processes of the posterior urethra a solution, $\frac{1}{2}$ to 1 per cent., is

excellent for irrigation or instillation. If the posterior urethritis is acute, it is necessary to wait until the acute symptoms have subsided under diet and morphine before beginning the large treatment.

ARCH. OF PEDIATRICS, Vol. xv., No. vi.

Immunity from Diphtheria conferred by Antitoxin.

Dr. F. Gordon Morrill's report of the results obtained in the Children's Hospital of Boston is of much interest, his experience, extending over three years, showing that immunity can be obtained by promptly injecting exposed cases with an adequate dose of antitoxic serum.

The evidence presented certainly seems to bear out this belief, as the observations have been made with great care; 1,808 patients received immunising doses, about 3,000 injections of antitoxin being given. From his experience Dr. Morrill concludes that:—

(1) Immunity, no matter how great the exposure to diphtheria, may be conferred, for at least ten days, by the injection of a small dose (100-250 units) of serum, provided it is given twenty-four hours previous to actual infection.

(2) That a large dose (250 units for a child of two years up to 500 units for one of eight years or over) will confer safety for three weeks.

(3) That no harm will result from the treatment in a vast majority of cases of *sick* children, and probably in no case of a healthy child, provided the serum used is pure.

In the 1,800 cases reported the only ones in which anything like dangerous symptoms appeared were in those of a boy with a splenic leucocythemia, and another with nephritis. In the latter instance the antitoxin caused a distinct increase of the albuminuria and dropsy. In another case in which the same clinical symptoms were present and the urinary analysis corresponded very closely with that of the first, the injections produced no unpleasant effects. Of the 3,000 injections given, with the above exceptions, apart from an occasional urticaria, far more rare now than formerly, and an insignificant and transitory albuminuria, nothing worth noting followed. Very rarely was the antitoxin omitted or postponed, no

matter how ill the patient. In one instance of very severe cerebro-spinal meningitis, in which no injections were given, the child contracted diphtheria, which proved fatal.

In conclusion, the author expresses the opinion that a physician who fails to promptly immunise a family or close community in which diphtheria breaks out, fails in his duty.

JOHNS HOPKINS HOSPITAL BULLETIN,
August.

Cocaine Anæsthesia in Herniotomy and in Operations for Thyroid Tumours.

Dr. H. W. Cushing calls attention to the great advantages of cocaine when a general anæsthetic is contra-indicated. Operation may be necessary in old people with chronic bronchitis or pronounced cardio-vascular changes which render ether dangerous. Thus a man, aged sixty-seven, with chronic bronchitis and emphysema, systolic murmur, and calcified arteries had an incarcerated hernia which was operated on by the Halsted method. If a local anæsthetic could not have been used an operation would hardly have been deemed advisable. The skin was infiltrated with a weak Schleich's solution. Fortunately no further cocainisation was necessary, as this method is hardly applicable to deeper structures. The patient suffered little pain, only during the ligation of vessels, the division of the internal oblique muscle, and the tightening of the deep silver mattress sutures.

Another condition in which this method is useful is operation for strangulated hernia where the patient is in such a state of shock that the effects of etherisation are dreaded, especially where there is much vomiting.

Again, patients with enlarged thyroids take ether badly. The resulting cyanosis makes the operative field bloody. Moreover, as Kocher has shown, the trachea is often distorted and flattened, and manipulations may completely close it.

A man, aged forty-four, had a thyroid tumour for ten years, which was beginning to embarrass respiration. The left half of the thyroid and the tumour were removed. Before operation a quarter of a grain of morphia was given. The skin alone was anæsthetised. The operation was practically bloodless. The tying of the large veins

alone caused pain. Manipulation of the tumour frequently embarrassed his respiration, but he always gave warning of his dyspnoea. The advantage of a bloodless field was demonstrated at the end of the operation, when the recurrent laryngeal nerve was seen arching up through the last bit of tissue that held the tumour; had this tissue been bloodstained it would doubtless have been divided.

The Causes of Recurrence after Removal of Adenoid Vegetations.

Heermann (*Therapeut. Monatshefte*, August, 1898) states that removal of adenoid vegetations is followed by a permanent cure in but 60 per cent. of all cases, and that in the other 40 per cent. the symptoms recur frequently, causing permanent deafness and stupidity. This has led the author to inquire whether the enlarged pharyngeal tonsil is the sole cause of the symptoms. If it were its removal should cure permanently, though relapses might be explained if the growths were usually due to tuberculosis, as Trautmann believed. But against this view are the following facts.—(1) The tubercle bacillus is found in but 2 per cent. of all cases. (2) The vegetations have not the characteristic structure of granulation growths. (3) Though common in the children of phthisical, they are often met with in the children of healthy parents, and recur after removal just as frequently in the latter as in the former. Heermann claims that there is an invariable relation between recurrence and the presence of hypertrophied turbinate bones. Several cases are mentioned where all the symptoms of adenoids were present without the vegetations, but where there was swelling of the turbinate bones, in some cases caused by foreign bodies introduced by the young patients. Further nasal obstruction, whether by foreign bodies or by chronic catarrh, may lead not only to the symptoms of adenoid vegetations, but to their actual formation, and the author succeeded in producing typical post-nasal growths in young guinea-pigs by blocking their nares with glass beads. From an etiological standpoint he therefore divides all cases of adenoid vegetations into two groups. (1) Those which are primary and probably depend on a tuberculous diathesis. They are cured by one thorough removal. The nose may be affected secondarily, but recovers after the adenoids are removed. The facial type is

that with a narrow nose. (2) Those which are secondary to nasal disease. The turbinate bones become hypertrophied most often through a chronic coryza. There is deficient ventilation and removal of secretion, through the irritation of which the pharyngeal tonsil hypertrophies. In such a case the vegetations may be removed, but the cause remains and recurrence is certain. The facial type is usually that with a thickened nose; the anterior nares is often surrounded by eczematous scabs. The writer concludes that—(1) The diagnosis of adenoid vegetations is not always easy. (2) Whether they are primary or secondary must be ascertained by examining the nose. Primary adenoids should be removed at once; secondary should be left until the nasal disease has been treated. The following treatment for the hypertrophied turbinate bones is recommended. The nostrils should be painted with a $\frac{1}{2}$ per cent. cocaine solution once or oftener in the day, and sodium soziodolate (3 parts) with powdered borax (12 parts) insufflated. After a week the swelling of the turbinates will have subsided in most cases (in children), and the adenoids may then be removed. The child should lie in bed for two days after the operation, and the nasal insufflations continued till cure is complete. Occasionally, in severe cases, the mucous membrane may require cauterising with trichloroacetic acid. If the above treatment is persevered with, recurrence can be prevented with certainty. (4) The condition of the nose should decide also the question whether to operate on adenoid vegetations complicated by middle ear disease. If the nostrils are permeable, operation has an excellent effect—not otherwise. The same rule of attacking the nasal trouble first must be followed.

The Treatment of Addison's Disease by Suprarenal Extract.

Pickardt (*Berlin Klin. Wochenschr.*, August 15, 1898) has given tabloids of suprarenal substance in a case of Addison's disease. The ingesta and egesta were analysed carefully with a view to ascertaining their effect on metabolism. He found that in the period preceding the administration of the suprarenal substance it was easy to keep the patient in nitrogenous equilibrium, but directly the "specific" treatment was begun, the tissue albumen diminished, though other conditions remained

unaltered. The loss of nitrogen in four days was 18.02 grammes, equalling about 140 grammes (nearly 5 oz.) of flesh, which was also the observed loss of body weight. The nitrogenous excretion in the urine increased progressively also. This effect was, therefore, injurious. One other case treated by the extract where nutrition was investigated at the same time, has been published by Senator, who was not able to recognise any increased elimination of nitrogen, or, indeed, any other result, good or bad, except improved appetite.

The Surgical Treatment of Pericarditis.

Brentano (*Deutsche Med. Wochenschr.*, August 11, 1898) advocates opening the pericardium whenever pericardial effusion is so extensive as to endanger life. A rib should be resected; local anæsthesia is often sufficient. After freeing the cartilage of the fifth rib from the intercostal muscles the author divides it in the middle, raises and frees each cut end, and cuts off the inner half close to the sternum, the outer near the bony rib. There is very little danger of wounding the pleura, which is here protected by the triangularis sterni muscle. The internal mammary artery runs in front of this muscle, and should be ligatured in two places and divided, since, if wounded accidentally it may give great trouble. After dividing the fibres of the triangularis sterni, the pericardium comes into view, the fold of the pleura over it is pushed aside, an exploring syringe introduced to make sure of the pericardial contents, and the pericardium incised freely. It is sometimes difficult to empty the sac completely, as the heart lies close to the wall of the thorax, and tends to close the opening in the pericardium. The edges of the sac are then sewn to the skin wound, the cavity is washed out with sterile water and cleaned with sterile wool, strips of iodoform gauze being used as a drain. After-treatment consists in washing out the sac with sterile water or weak lysol solution. The other two possible methods of evacuating pericardial fluid—viz., simple puncture and incision through an intercostal space without a preliminary rib-resection—should be abandoned entirely. Simple puncture has the following disadvantages:—(1) There is no place on the chest wall where puncture can be performed without danger of wounding the heart and pleura. (2) The heart has often been wounded through a wrong diagnosis

of pericardial effusion, and this accident may happen if there are adhesions which in places obliterate the pericardial cavity. (3) Also the old idea that the heart sinks by its own weight to the bottom of the effusion, and that it therefore approaches nearer to the posterior wall of the thorax, is wrong. On the contrary, the heart is lifted slightly upwards. The chief collection of fluid is behind the heart, unless its normal position is altered by adhesions, and on tapping the coronary arteries and veins are endangered. (4) The pleura is still more likely to be wounded than the heart; in fact, in most cases paracentesis is performed through the pleura, since recent researches show that the pleura, even at the level of the fifth and sixth rib, reaches under the sternum in two-thirds of all cases, and cannot, therefore, be avoided. In many cases this wound may have no evil consequences, but it is probably the cause of the pleural effusion which frequently follows a few days later. (5) Lastly, simple paracentesis hardly ever empties the sac completely, and often (in twenty-three out of eighty of West's cases) it must be repeated because the fluid re-collects. At each fresh puncture the danger to life is increased; fresh adhesions may have formed, and may lead to a wound of the heart, or to such a division of the sac into compartments that it is impossible to empty it. Simple incision through an intercostal space is almost as unsatisfactory; being close to the sternum the ribs cannot be pressed apart. The pleura is wounded almost inevitably, and the internal mammary artery is very likely to be. If the latter is cut it will probably be necessary to resect one or more ribs before it can be ligatured. Again, it is impossible to recognise thickenings of, or partial adhesions between, the parietal and visceral layers of the pericardium in the bottom of the funnel-shaped wound. Old-standing heart trouble, more especially where there has been previous pericarditis, is a contra-indication to the operation.

A Rare Symptom of Intolerance to Antipyrin.

Dr. Ceamus (*Gazette des Hôpitaux*, Aug. 25, p. 889) publishes the case of a woman, aged thirty-three, who, a quarter of an hour after taking half a gramme of antipyrin was seized with continual and intractable sneezing, which

lasted twenty minutes, and was accompanied by coryza. The latter persisted for an hour, with some difficulty in respiration.

GAZETTE DES HÔPITAUX, Sept. 6.

Modification in the Organs Produced by the Bicycle.

MM. F. Regnard and A. Bianchi by means of the phonendoscope, obtained a rapid reproduction of the organs of the first four bicyclists in a seventy-two hours' race before, immediately after, and several days after the race. They arrived at the following conclusions.—The organs were much diminished, especially the spleen, liver, and stomach. The subcutaneous fat was also diminished. These changes are due to insufficient food during the race, and to the loss of force, want of sleep, and emotion. The heart and lungs were scarcely diminished. As a result of the attitude and exertion, all the abdominal organs were elevated from two to four centimètres, and the heart from two to five.

GAZETTE DES HÔPITAUX, Sept. 8.

Erysipelatous Pneumonia.

Drs. Artaud and Barjon publish a case of erysipelatous pneumonia, which they claim as the second in which the erysipelatous nature of the pneumonia has been proved bacteriologically.

A lad, aged seventeen, had facial erysipelas from which he completely recovered. A month later he was seized with rigors accompanied by pain in the right side, and cough. The expectoration was gummy, slightly purulent, and adhered but little to the vessel; there was no hæmoptysis. Numerous streptococci were found. The lower two-thirds of the thorax on the left side was dull. Rhonchi were heard at the superior and middle portions of the lung, and rales at the base. On the right side the signs were less marked; there were some sibilant rhonchi but no dulness. The crisis occurred on the eighth day, and the patient recovered.

A rabbit was inoculated in the ears with the sputum; typical erysipelas developed, which proved fatal. A mouse was also inoculated, and the fatal septicæmia, which characterises infection of the animal with the pneumococcus, did not develop.

The case was thus one of streptococcus pneumonia. This might have been suspected from the clinical features, which differed from those of ordinary (pneumococcus) pneumonia in the paroxysmal whooping-cough-like cough, the character of the sputum, the presence of bronchitic rales, and absence of fine crepitant or subcrepitant rales.

INTERNAT. CENTRALBLATT FÜR LARYNGOLOGIE.

Basedow's Disease.

De Grandmaison advances the theory that Basedow's Disease is explained by a permanent irritation either of the vaso-dilator branches of the cervical sympathetic, or the central nucleus of that nerve. His reasons are:—(1) The successful results of resection of the cervical sympathetic, obtained by Jaboulay, Abadie, Jonnesco, Gerard Marchant, and Reclus. (2) His own observations. In thirty-two cases which he examined in the Hôpital Laennec, he noticed profound nervous disturbances in nineteen instances, which almost invariably presented the picture of hysteria. As an objective sign, which he regards as pathognomonic, he mentions the asymmetry of the face due to contracture, which Charcot and Marie described under the name of hemispasmus glossolabialis.

Pitre cites a case, terminating fatally, in which diabetes mellitus complicated the morbus Basedowii. As in cases reported earlier by Sonques and G. Marinesco, he regards the secondary diabetes as having a direct connection with the first trouble, and not as an intercurrent malady.

Abadie believes that the disease is due to an irritation from the brain-centre passing downward through the vaso-dilator branches of the sympathetic, and the resection of the cervical sympathetic is the only rational treatment. He considers the treatment by thyroid extracts to be of help in diagnosis in doubtful cases. If under the treatment the condition grows worse, Basedow's Disease is present; while, if the condition improves, the case is only one of simple goitre.

Péan states that the disease is not amenable to therapeutic measures. Of the operative procedures, exothyropexy and resection of the sympathetic still require further proof to establish their

value. Thyroidectomy, however, has even in severe cases brought about numerous and permanent recoveries. With small, easily enucleated and non-vascular goitres the operation is simple; with a short horizontal and vertical incision it is accomplished in a few minutes. In complicated cases tie off the vessels and remove the tumour piecemeal. Subsequent myxoedema is rare and transient in character.

The Treatment of Puerperal Convulsions by Lavage of the Blood.

Dr. Caillaud (*Gazette des Hôpitaux*, August 16 and 18, p. 857) relates the following case, which, as the *Gazette* remarks, shows the value of a method little used, though of proved utility—lavage of the blood:—

A young woman, aged twenty-two, had a premature but normal labour at the seventh month. At the end of the first stage she was seized with severe convulsions. A macerated foetus was delivered with the forceps. Chloral was given in large doses by the rectum, but she became comatose, and violent attacks of convulsions continued for ten hours. The temperature was 105·8, and the urine contained much albumin. 200 grammes of blood were drawn from the median cephalic vein, and a litre of artificial serum (seven grammes of chloride of sodium in a litre of distilled water at 102 deg.) was introduced into the vein. Only one more attack occurred—ten minutes after the injection. A large quantity of urine was passed an hour afterwards. The coma continued, and two more injections were given, but subcutaneously. She regained consciousness about twenty-four hours after the first injection. As to the relative merits of subcutaneous and intravenous injections, the writer points out that the former are easier of performance, and the latter quicker and surer, but liable to be attended by phenomena of reaction (yawning, clattering of the teeth, &c.), which, however, are not serious. He makes no mention of another method of inducing diuresis much easier of application than the two mentioned, and which, if slower in its action, would, at any rate in the majority of cases, be equally efficacious—the administering of large quantities of water by the rectum. This method is alluded to in another article in our *Epitome*.

PROGRÈS MÉDICAL, September 17, 1898.

The Treatment of Abortion: "Abdomino-Vaginal Expression of the Uterus."

M. Pierre Budin, in an important lecture on this subject at the Tarnier Clinique, recommends the removal of retained placenta by the fingers, and condemns the curette. The use of the curette is a blind procedure. Its position is not always exactly known; sometimes only the cavity of the cervix has been entered when the curette has been supposed to be in the uterus. It may be insufficient; débris of placenta in the corners of the uterus cannot always be detached. It has happened that, in spite of scraping, washing, and cauterising, the practitioner has been surprised to find on the following day a foetus 6 to 7 centimètres long, without legs, expelled from the uterus. There are often bands in the uterus between which remain parts not detached by the curette. The curette is dangerous. It cuts the sound mucous membrane, and opens portals for infection; it may produce hæmorrhage difficult to arrest. Finally, it has caused perforation of the uterus. Several cases have been published. A Berlin doctor was sentenced to several months' imprisonment on account of this accident. M. Budin was once asked to curette a young woman who was seriously ill after abortion. He was careful not to do so, for the uterine tissues were softened, and the posterior wall was very thin. The patient died in a few hours; at the necropsy it was evident how easily the uterus might have been perforated.

If, then, there is any other procedure which can be employed, it ought to be adopted in preference to the curette. Such a procedure exists; it is the digital clearing out of the uterus. The following is the method recommended by M. Budin when it is necessary to extract the placenta after abortion.

Chloroform is administered, for there must be complete relaxation of the abdominal walls. The most complete antiseptic precautions are taken. The cervix is dilated by introducing, first, the index finger, and then the index and middle fingers. If the uterine tissues are too resistant the uterus is brought down with a vulsellum, and the cervix is dilated with Hegar's bougies. When the dilation is sufficient—when two fingers can be introduced

in a three to four months' abortion, when one finger can be introduced in a one to two months'—the digital clearing out is performed. A hand on the abdomen fixes the uterus, the fingers in the interior detach slowly, regularly, and completely the placenta. If the placenta is too large to be extracted through the uterine orifice, then M. Budin has recourse to a procedure which he has employed since 1895, and which he terms "abdomino-vaginal expression of the uterus." The placenta is torn into two or three pieces with the index or middle finger. Then the fingers, with their palmar surfaces directed towards the symphysis pubes, are placed in the posterior fornix of the vagina; they are applied to and depress the uterine wall. The other hand, placed on the hypogastrium, depresses strongly the abdominal wall, and with the fingers, which are flexed and applied to the fundus, and the palm, which is applied to anterior uterine wall, pressure is made on the uterus. The organ is thus compressed between the two hands, and the fragments of placenta and membranes are forced through the cervix. The uterus is then explored to make sure that nothing remains, and washed out with a solution of perchloride of mercury (1 in 4,000). After this M. Budin swabs the interior of uterus, and when all débris have been removed, he applies glycerine and creasote (1 to 5, or equal parts) followed by a vaginal sublimate douche to remove excess of creasote. If any hemorrhage follows, the uterus and vagina are packed with iodoform gauze.

As to the various forceps invented for the removal of the placenta, though recommended by the late Professor Tarnier, M. Budin condemns them equally with the curette. They are dangerous. At the Obstetrical Society of Berlin, in 1894, Dr. Alberti related the case of a woman whom he had received into hospital. A practitioner, after curetting, introduced a polypus forceps to entract the débris of an abortion. He had the disagreeable surprise of finding that he had drawn through the os a coil of intestine. He surrounded it with iodoform gauze and sent the patient into hospital. Laparotomy was performed. A loop of intestine, seventeen centimètres in length, was so grasped by the internal os that it had to be released by incision. The uterus was sutured and curetted. The woman recovered,

but four weeks afterwards had to be curetted twice for hæmorrhage. This communication was the starting-point of a series of similar revelations by Veit, Gusserow, Olshausen, Orthmann, and Martin. Several of these cases terminated fatally.

NOUVELLE ICONOGRAPHIE DE LA SALPÊTRIÈRE,
Mai et Juin.

Myositis Ossificans.

MM. A. Weill and J. Nissim contribute a valuable and erudite article on this very rare disease in which they publish a celebrated case which has been under the observation of authorities in different parts of Europe. Albert Schwartz, aged thirty-two, was born in the little Roumanian town of Toultscha, where he carried on the business of grocer. His family and previous history present nothing of importance. The disease began twelve years ago, in April, 1884, when suddenly the tempero-maxillary articulation, the right shoulder, and the right arm became red, swollen, and very painful. This condition, which was accompanied by pyrexia reaching to 100.4, kept him in bed for three months. Then he was able to resume his occupation, but the right arm remained powerless, and the jaws remained ankylosed. After the onset of the disease masses of bone of new formation were noticed in the affected regions. In the following year, in the same month, the fever reappeared. The swelling, redness, and pain were localised this time in the neck, and behind and on the right side in the superior half of the thorax. These symptoms lasted also three months, and gradually amended, leaving the neck stiff, and the prominence of the right great dorsal muscle ossified.

In 1886, a third attack occurred. The right hip-joint was involved and left ankylosed and surrounded with osseous formations. In 1887, the right buttock was implicated; in 1888, the middle of the thorax in the situation of the great dorsal muscle; in 1889, the shoulder arm, popliteal region, calf and foot, on the left side. This sixth attack was the last. All occurred in the month of April.

The patient travelled through Europe, and was seen by Billroth, Virchow, and Kraske. At Paris, in 1896, he was presented to the Academy of Medicine by Dr. Weil, when his condition was as follows:—

The intelligence was unimpaired and the speech easy in spite of ankylosis of the jaws. He could execute no movement of the head. The inferior intercostal muscles were hard; the respiration was therefore principally abdominal, but partly superior costal. The arms were symmetrically affected; the shoulder-joints were ankylosed; the triceps was completely ossified, but the biceps brachialis anticus and the muscles of the forearms were intact. The back also was symmetrically affected, showing bony prominences replacing the muscles. Excepting ankylosis of the hip, the left lower limb was almost untouched. The right, on the contrary, was much affected: the hip was ankylosed, there was a large mass of bone in the popliteal region connecting the femur and tibia and immobilising the knee. The bones of the leg and the foot were enlarged.

The etiology and pathology of myositis ossificans are obscure. There are many theories, and none are satisfactory. It is a disease of early life. Out of forty-two cases it began in the first two years of life in fifteen. Signs of the disease have been noticed fourteen days after birth, and even congenital lesions have been described. The oldest patients were nineteen, twenty-one, twenty-two, twenty-six, and thirty-five years at the onset. Males are affected more frequently than females in the proportion of thirty-eight to twelve. The Germans and Anglo-Saxons are much more liable to the disease than other races. Heredity seems to play no part.

As to the pathology. Virchow, in order to explain myositis ossificans, created an osseous diathesis. Pinter regards it as a constitutional disease. Testelin, Dambressi, and Hawkins consider it of rheumatic nature; its onset after exposure to colds lends some support to this theory. Volkmann terms it an osseous affection of growth. Kohts and Friedreich believe it to be a primitive myopathy; but it is known now that the disease affects not only the muscles but the whole locomotor apparatus. MM. Weill and Nissim regard it as a tropho-neurosis.

The duration of the disease is variable. It may proceed very rapidly, and immobilise all the joints in a few years; in other cases the evolution takes fifteen or twenty years. It has no direct tendency to cause death; it respects the organs essential to

life, but favours the development of inter-current affections of the respiratory organs, which may prove fatal.

Treatment appears to be useless.

Otitis from Influenza.

In the *Semaine Médicale*, August 31, 1898, Dr. E. J. Moure has published an article on this subject. He divides otitis from influenza into three forms. 1. Trivial, comprising otalgia, otitis externa, myringitis, simple catarrhal otitis media (hyperæmic or exudative, serous or hæmorrhagic). 2. Medium, comprising suppurative otitis media and primary mastoiditis. 3. Serious, comprising otitis interna, acute osteomyelitis (panotitis, leptomeningitis.) As to otalgia, Kaufmann and Braine have described it as a condition of violent pain preceded by pyrexia, examination showing nothing to account for the symptoms. Sometimes there was also passing tinnitus, but no auditory trouble was left as a sequel. These writers consider otalgia to be of a neuralgic nature. A more common affection is hyperæmic myringitis and sanguineous extravasations occupying the external meatus, or the tympanic membrane at its periphery. These hæmorrhages have been thought to be characteristic of influenza. Symptoms are slight, and pain is almost negligible. The affection is often limited to the tympanic membrane. But in a severer form the tympanum is filled with a serous or sero-sanguineous fluid, which may remain sterile for months. But if perforation of the membrane occurs, or if contaminated air enters by the Eustachian tube suppuration supervenes. The duration of the suppurative period is variable, but most writers insist on the rapidity with which it becomes cured. But in some cases, especially when the superior part of the tympanum is perforated, the antrum is affected, and the suppuration becomes chronic (secondary mastoiditis). There are other cases in which the mastoid is affected without the slightest tympanic lesion (primary mastoiditis). In these cases pain is the predominant symptom; it prevents sleep, and the mastoid process is tender.

Inflammation of the internal ear produces characteristic symptoms—tinnitus, deafness, vertigo, vomiting, &c.

A form of disease much graver than any of the preceding is panotitis. The malady is analogous to

acute osteomyelitis, and there is rapid destruction of bone. The fever and other symptoms are severe, and the patient often succumbs to pyæmia or leptomeningitis in a few days, even in spite of radical treatment.

Hæmorrhagic myringitis should be treated by warm injections and instillations of carbolic acid in glycerine (1 in 5 or 10), or by puncture of the projecting part if there is pain. Catarrhal otitis media often becomes cured spontaneously, or one or two inflations of the Eustachian tube may be sufficient. When the inflammation is purulent, and when there is much pain and a tendency to perforation paracentesis should be performed. If there are symptoms of mastoiditis, operation should be performed even before there is any external swelling, for, in influenza, necrosis rapidly takes place, and in four or five days the external table may be completely necrosed, or there may be a perforation on the side of the cranial cavity.

Therapeutische Monatshefte, August, 1898,
p. 426.

Removal of the Causes of Recurrence after Adenoid Vegetation.

The frequency of the occurrence of adenoid vegetations and the gravity of the effects resulting from them renders any addition to our knowledge of these growths a matter of considerable interest and importance. Dr. Heermann admits, with all other authorities, that these impediments to respiration should be removed, and that this should be done as early as possible. The proportion of patients, however, who are permanently relieved is only 60 per cent. of the whole number treated. In the remaining 40 per cent. the evil symptoms either persist throughout, or recur very shortly after the removal of the growths. The question therefore arises whether the adenoid vegetations are the actual cause of the patients' ill-health in all cases. Dr. Heermann narrates two cases occurring in children in which foreign bodies inserted into the nostrils, and allowed to remain there, produced a condition exactly resembling the complex symptoms produced by adenoids, and he also showed, by experiments on sucking-pigs, that the insertion of glass beads into the nostrils was capable of producing an "adenoid type" in these

animals, with production growths behind the obstruction. He concludes that there are two varieties of these excrescences—in one they are primary and probably connected with the tubercular diathesis; in the other they are secondary to swelling of the mucous membrane of the turbinated bones, arising out of continued catarrh. In this latter class the removal of the growths alone does not suffice to cure the disease, since the obstruction remains and the "adenoids" recur rapidly after removal, owing to persistence of the original exciting cause.

Treatment then should be directed to the condition of the nasal mucosa, as well as to the growths themselves. The nose should be swabbed with $\frac{1}{2}$ per cent. cocaine solution, and a mixture of 3 parts of sodium sozoiodolate, with 12 parts of powdered boracic acid should be insufflated. The swabbing must be done several times a day in severe cases; in others, once daily is sufficient. Caustic applications such as trichloroacetic acid are seldom necessary.

An incidental advantage of previous treatment of the anterior nares is that the adenoids can nearly always then be seen with a speculum. In adults, posterior rhinoscopy may be used. Dr. Heermann prefers Kirstein's knife, or Goldstein's ring-knife for the removal of adenoids. The occurrence of inflammation of the middle-ear is no bar to the operation, but in all cases the condition of the nasal mucous membrane should be first attended to.

DEUTSCH. MED. WOCH., No. 33, p. 522.

The Pathogenic Nature of Loeffler's Diphtheria Bacillus.

SCHANZ.

There are certain cases which are clinically diphtheria, but in which the bacillus cannot be found. A bacillus practically identical with it has been found in many other conditions, both in disease—as in pulmonary tuberculosis, hernia, chancres, *ozæna*, and others, and in health, as in saliva from a healthy individual. Hitherto it has been the fashion to assume that the true diphtheria bacillus, and the bacillus found under these various other conditions, are distinct; the latter is called the pseudo-diphtheria bacillus, and different observers have laid down different rules for the differentiation of the two; these, however,

agree only in the one point—that the pseudo-bacillus is not toxic, as the “genuine” Loeffler’s bacillus is. Under certain circumstances, Loeffler’s bacillus may lose its toxic properties, which it may regain if injected with a culture of streptococci (Roux and Yersin), or a dose of the toxins of a virulent diphtheria culture into animals (Trumpp), whence the one remaining criterion of the genuine organism is proved to be of no value, and the only scientific course is to recognise the identity of the two. It seems then probable that a widely-distributed saprophyte, such as the bacillus is, cannot alone be the cause of diphtheria, but that some other circumstance is needed to give it the power of multiplying in the body and producing its poison. An inflammation already excited in the upper air-passages fulfils the necessary condition. In the membrane formed in the throat the bacillus grows and elaborates its poison, which affects the whole body. Others have explained the process by a symbiosis set up between the diphtheria bacillus and the streptococcus pyogenes. Against this stands the fact that in xerosis (ophthalmic diphtheria) there are found many streptococci, and very few Loeffler’s bacilli, and the latter are not virulent. Franke has, indeed, endeavoured to distinguish the xerosis bacillus from the diphtheria bacillus, and from the pseudo-diphtheria bacillus alike, but not satisfactorily. Dr. Schanz quotes in conclusion two cases in which diphtheria bacilli were obtained from wounds in the eye after cataract operations, in neither of which diphtheritic infection occurred.

Mixed Infection in Pulmonary Tuberculosis.

Schabad (*Zeitschrift für Klin. Med.*, Bd. 33, p. 466) working under the direction of Afanassiew, furnishes an important contribution to this subject, so closely connected with the active exploitation of specific remedies for tuberculosis at this time. In all he has examined thirty-one cases clinically, and seventeen of these also post mortem. The author’s conclusions are as follows:—(1) By mixed infection in tuberculosis should be understood cases in which the associated bacteria are in the lung-tissue (alveoli or capillary bronchi) or in the blood. (2) The finding of pathogenic bacteria in sputum (Kitasato’s method), even in pure culture, does not suffice to prove a mixed

infection. Experience shows that these bacteria, the pyogenic streptococci excepted, do not all come from the lung. (3) It is very important not to confuse the pyogenic streptococci with the streptococci of the mucous membranes. These resemble the former, but differ essentially in biological character and in the absence of pathogenicity. The mucous membrane streptococci are harmless parasites, but the genuine pyogenic streptococci are of great prognostic importance, as they cause the larger proportion of all mixed infections in tuberculosis. (4) Rarer than streptococcus infection is that with tetragenous-cocci and pneumococci, or double infections with one of these and staphylococci. (5) Secondary infection usually complicates the later stages of tuberculosis, and rapidly causes a fatal outcome. Almost all autopsies of tuberculous cases prove this. (6) The importance of secondary infection in the pathological process consists in this: that it either takes part in the pneumonic process always present in tuberculosis, or, if not actually the cause of exudation, exerts an influence on the general condition of the patient and on the fever by the toxins, and also assists in cavity-formation. It can also cause fatal septicæmia. (7) There are undoubted cases of tuberculosis that show all the symptoms of the hectic stage, and end fatally, without the action of any other organism than the tubercle bacillus. (8) Uncomplicated, progressive pulmonary tuberculosis is characterised by hectic fever of inverse type. In mixed infection with streptococci the typical curve is rarely observed, the temperature being usually remittent or approaching the continued type. (9.) Normal temperature characterises the stationary uncomplicated tuberculosis. Mixed infection with normal temperature is not very probable.—*Amer. Jour. Med. Sciences.*

Tuberculosis.

When we are told that tuberculosis accounts for one out of every seven or eight deaths throughout the world, when we call to mind the protracted suffering endured by its victims, who are often the brightest and most intelligent of our population, and when we reflect that from the earliest to the latest stages of life all men are subject to its ravages, it seems high time that civilisation should

take strong steps to stamp out this foe to the race, a foe more formidable and far more destructive than war, famine, and pestilence together.

The attitude of the public, and, it must be sorrowfully confessed, to a considerable extent of the profession, has hitherto been largely one of *non possumus*, but in view of the encouraging results of recent researches in bacteriology, such a position is no longer tenable, and we rejoice to find that at last active steps are being taken to enlighten the general public in this country, and stimulate all concerned, professional and lay, to an energetic campaign against man's worst enemy—the tubercle bacillus.

One important step in advance has already been gained in the almost unanimous recognition of the fact that tuberculosis, whether occurring in man or in the lower animals, is a distinctly preventible disease, and we may now reasonably hope that before many years have passed the world will come to understand the folly of a fatalistic submission to this terrible destroyer of human life.

A Tragedy of the Great Plague of Milan in 1630.

BY ROBERT FLETCHER, M.D.

Manzoni, the famous Italian writer, in a small work published in 1840, entitled "*Storia della Colonna Infame*," has told the story of a column erected in Milan during the great plague of 1630, which bore the following inscription in Latin:—"Here, where this plot of ground extends, formerly stood the shop of the barber Giangiacomo Mora, who had conspired with Guglielmo Piazza, Commissary of the Public Health, and with others, while a frightful plague exercised its ravages, by means of deadly ointments spread on all sides, to hurl many citizens to a cruel death. For this, the Senate, having declared them both to be enemies of their country, decreed that, placed on an elevated car, their flesh should be torn with red-hot pincers, their right hands be cut off, and their bones be broken; that they should be extended on the wheel, and at the end of six hours be put to death, and burnt. Then, and that there might remain no trace of these guilty men, their possessions should be sold at public sale, their ashes

thrown into the river, and to perpetuate the memory of their deed the Senate wills that the house in which the crime was projected shall be razed to the ground, shall never be rebuilt, and that in its place a colum shall be erected which shall be called Infamous. Keep afar off, then, afar off, good citizens, lest this accursed ground should pollute you with its infamy. August, 1630."

This barbarous sentence was executed in all its details, and for 150 years this pillar, intended to blast the memory of two really innocent persons, stood as proof of the ignorance and credulity of their judges.

The story of the event is this: On the morning of June 21, 1630, during the prevalence of the plague in Milan, a woman of the lower classes saw a man going down the street who was writing on paper. He wiped his fingers on the wall of a house, probably to get rid of ink-stains; she became convinced that he was smearing deadly ointments to spread the pestilence. The Senate was informed, and he was arrested. The scrivener with the ink-horn in his belt proved to be a certain Guglielmo Piazza, a commissioner of health, a petty officer employed to report cases of disease. He stoutly denied all knowledge of crime through two applications of torture. But in his cell, broken down with the effects of the torments and dreading their renewal, he yielded to the insidious suggestions of those around him. He confessed his guilt and declared that he obtained the death-dealing ointment from the barber Giangiacomo Mora. He was arrested, but likewise declared his innocence, avowing that he did not know Piazza. But he too confessed under torture. From that time until their execution these two wretched men vied with one another in manufacturing falsehoods.

Cancer of the Rectum:—Dr. J. M. Mather. (*Med. Mirror*, St. Louis), condemns the Kraske operation in cancer of the rectum, and he says the high operation is seldom justifiable, and deprecates opening the peritoneal cavity, and preferring the circular to the sacral method. He recommends that all malignant growths within reach of the finger, which can be circumscribed, should be extirpated.

EPITOME OF CURRENT LITERATURE.

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MEDICINE.

ST. LOUIS MED. AND SURG. JOUR.

The Development of Serum Therapy.

Natural immunity exists where individuals or races are less susceptible than others to certain diseases, acquired immunity, where one attack of infectious disease confers more or less immunity against subsequent attacks.

Artificially acquired immunity dates from the discovery of Jenner (1766), that the lymph taken from the vesicles of cowpox would protect the vaccinated individual from smallpox.

Pasteur in 1880 began the publication of a series of brilliant experiments on the production of artificial immunity. He found that if microbes were weakened by age or heat, or exposure to the atmosphere, animals inoculated with these weakened cultures would have a mild attack of the disease in question, even after inoculation with the most virulent cultures.

He perfected his methods of attenuating his microbes, and succeeded in immunising animals against several of the infectious diseases.

Pasteur worked with the germs themselves, but it was soon discovered that the toxic products of the germs, the filtered cultures from which all the germs were removed, could produce immunity. The first satisfactory demonstration of this discovery was given by Salmon and Smith in 1886. They succeeded in immunising pigeons against the germs of hog cholera by previous injections of the sterilised cultures obtained from these germs.

Similar results were reported by Roux, in 1888, with anthrax and symptomatic anthrax. The first published results on immunisation in diphtheria were those of Loeffler. In May, 1888, he inoculated a guinea pig with diphtheria; the animal sickened, but recovered after three weeks. It was then inoculated a number of times with virulent cultures, but showed itself entirely immune.

In December, 1890, C. Fraenkel (*Berlin. Klin. Woch.*) published his reports on the immunisation of animals against diphtheria. He showed that there were several ways in which this could be accomplished. A day later (*Deutsch. Med. Woch.*, December 4, 1890) Behring and Kitasato published their reports on immunisation against diphtheria and tetanus.

They succeeded in immunising animals against tetanus and diphtheria by the injection of the filtered cultures from these germs. In 1891, the Klemperer Brothers reported similar results with pneumonia. Meantime, a number of investigators in various parts of the world were busy with another feature of the problem.

As early as 1872 Lewis and Cunningham demonstrated the fact that bacteria injected into the circulation rapidly disappear.

The first experiments made with the extra-vascular blood were conducted by Grohmann under the direction of A. Schmidt in his investigation of the cause of coagulation. It was found that anthrax bacilli, after being kept in plasma, were less virulent, as was demonstrated by their effect upon rabbits. Grohmann supposed that in some way the bacteria were influenced by the process of coagulation.

In 1888 Nuttall showed that defibrinated blood possessed germicidal power. Since then Nissen, Behring, Buchner, Christmas, Hankin, Bitter, and others have verified Nuttall's discovery. These experiments demonstrated the fact that the blood of the body has power to kill at least some bacteria.

Immunity to Poisons.—That certain animals possessed more or less immunity to certain poisons has long been a matter of common knowledge. The carnivorous animals, as the wolf and the vulture, thriving on putrid, toxic flesh. So it was known that many snakes and a few mammals, as the hedgehog, swine, and the ichneumon, were very resistant to snake poison.

In 1887 Sewall reported that he had immunised pigeons against the poison of the rattlesnake. He assumed an analogy between the venom of poisonous serpents and the ptomaines produced under the influence of bacterial organism.

An all-important discovery was that the immunity of one animal could be borrowed and transferred to another animal. The idea of the transfusion of the blood of healthy individuals or animals into persons weakened by disease or age is centuries old. King, physician to Charles I., in 1665, practised transfusion from the veins of one person into those of another. Denis, in France, who died in 1704, transfused the blood of the lamb into the veins of a weak patient. This operation was in common use until within the last few years. The first record we find of the use of the blood of an immunised animal for the protection of other animals is in 1887, when Foa and Bonome published their results. They rendered animals immune to the proteus vulgaris, the diplococcus of pneumonia, and the bacillus of chicken cholera, by treating them with sterilised cultures of the germs, and discovered that the blood drawn from the heart, or an infusion of the tissues of rabbits dead from proteus infection, injected intravenously into another rabbit, made this animal immune to virulent cultures of the proteus germs.

Hericourt and Richer, 1888, treated dogs with tubercle germs, and then transferred the blood from these dogs into other animals to cure and prevent tuberculous disease.

They injected cultures of staphylococcus pyosepticus into dogs; taking the blood from these dogs and injecting it into rabbits, they found that the latter animals would then resist infection with the staphylococcus.

In 1890, Ogata and Jasuhara, working in the Hygienic Institute of Tokio, showed that mice inoculated with lethal doses of anthrax germs could be saved if at the same time blood from an immune animal was injected subcutaneously.

Later in the year (1890) Behring and Kitasato showed that the blood of an animal which has acquired immunity against tetanus or diphtheria, when added to a virulent culture of one or the other of these bacilli, neutralises the pathogenic power of such cultures, as shown by inoculation into susceptible animals; and also that cultures from which the bacilli have been removed by filtration, and which in very small amounts kill susceptible animals, have their toxic potency destroyed by adding to them the blood of an immune animal.

In the experiments cited of Fraenkel, Behring, and Kitasato, it was clearly shown that the blood of immunised animals when injected into susceptible animals protected them from subsequent infection with virulent germs. Behring and Kitasato went further, and demonstrated that the immunised blood would protect animals not only against living germs, but also against filtered cultures or toxins, which were fatal to untreated animals. They showed that their protective inoculations produced an immunity which in mice lasted for forty or fifty days, after which it was gradually lost.

The next step forward was made by Kitasato, in 1891, in his further research on tetanus. He discovered that the blood serum of animals immunised to tetanus had not only prophylactic, but also curative properties. He demonstrated that mice, inoculated with tetanus germs, could be cured by an injection of serum, even *after* the tetanic symptoms had appeared.

This, the last in the long list of discoveries made by many workers along this line, made serum therapy possible. From this time on, the question was one of perfected methods: the best animals to use; methods for so increasing the immunising power of the blood that a small quantity would suffice for curative purposes; methods for determining the strength of the immunising serum; how to preserve and administer it.

Many investigators assisted in this work. Ehrlich, in his work on the vegetable poisons, Abrin and Ricin, showed that by beginning with very small doses, and gradually increasing them, the immunising power of the blood could be increased almost indefinitely. The animals treated would withstand hundreds of times the fatal dose of the poison. Behring contributed largely to the

work, and devised a method for measuring the immunising strength of the antitoxic serum.

Roux and Yersin showed that different cultures of diphtheria germs varied enormously in virulence.

Aronson and others devised means of increasing the virulence and toxicity of the germs. Aronson, after experimenting with many species of animals, showed that the horse was the most suitable for the production of antitoxic serum.

Behring and Wernicke (in 1872), published a paper upon the immunising and healing of experimental animals with diphtheria. They produced an antitoxin, and used this in treating guinea pigs, both for immunising these animals and for curing them after they had been infected with the diphtheria germ, or with its poison. Behring, in his "History of Diphtheria," 1893, discussed the possibility of treating children with diphtheria antitoxin, and points out that it is only a question of making the material more potent. He shows that of the material produced up to that time about 50 cc. would have to be given to a child of 20 kilogrammes' weight, assuming diphtheria in children to be of the same intensity as in guinea pigs.

In November, 1892, Aronson reported to the Berlin Medical Society on the immunisation of human beings against diphtheria; and in January, 1893, he further reported that he had succeeded for the first time in so increasing the immunising power of the serum that protective inoculations of children exposed to diphtheria was possible in practice.

In March, 1894, Aronson's serum began to be used in the Children's Hospital in Berlin. In February, 1894, Roux's serum began to be used in one of the hospitals of Paris, his preliminary report on the clinical results being made in May, 1894.

In September, 1894, in Buda Pesth, at the International Congress of Hygiene, papers were read by Behring and by Roux on the treatment of human diphtheria with antitoxin. These papers with their clinical reports of the value of the treatment at once aroused world-wide attention.

As so often happens, the persons who presented the results were not the sole discoverers. Antitoxin was not the discovery of any one man or set of men, but the cumulative result of the work of many investigators.

Little's Disease—Dr. Ch. Levi-Sirugue (*Gazette des Hôpitaux*, August 13).—Little's disease is an affection more spasmodic than paralytic of the lower limbs, or of the four limbs with predominance of the lower, of congenital origin or developed in the first years of life, not accompanied by intellectual troubles and susceptible of amelioration. Properly, it is not a disease, but a well-characterised group of symptoms with a

varied pathology. The malady may be noticed in the first weeks of life. Sometimes at this period several passing attacks of convulsions are observed. A certain stiffness of the limbs, noticed by the person who dresses the child, may be the first thing that attracts attention. Two years pass, and still the child does not walk. When examined after the age of three, the child is found less developed than normal; the most striking feature is the position of the lower limbs, which are semi-flexed and adducted; the knees are held against one another; the feet are in an equine position. The reflexes are exaggerated. The child raises the feet from the bed stiffly and with difficulty. If made to walk with someone supporting him, the mode of progression is very characteristic. The thighs are pressed together, and the limbs rotated inwards, the feet are in the position of equino-varus. The rigidity sometimes affects the upper limbs, and the face, but in less degree. There may be contracture of ocular muscles producing strabismus, or there may be nystagmus. Speech may be impeded by spasm; there may be dysphagia or laryngeal spasm. In some cases tremors, which may take the form of double athetosis or chronic chorea, or which may resemble those of paralysis agitans or disseminated sclerosis, are present. Or there may be spasmodic hemiplegia, or hemiparesis, or idiotcy.

The question of the pathology is still unsettled. Various cerebral lesions—cysts, sclerosis, meningeal thickenings, hæmorrhages—have been found. In the cord sclerosis of the pyramidal tracts secondary to the cerebral lesion is often present, but this change may be absent.

The causes assigned may be divided into two classes: obstetrical—hæmorrhage from difficult labours, asphyxia neonatorum, &c., and the various infectious diseases.

The treatment where syphilis is suspected is the administration of mercury and potassium iodide.

The symptomatic treatment consists of massage, Swedish gymnastics, the methodical education of the muscles. Tenotomy and transplantation of tendons may be practised for the deformities.

Paralysis of the Superior Facial in Hemiplegia from a Cerebral Lesion.—Dr.

Ch. Féré (*Nouvelle Iconographie de la Salpêtrière*). The existence of paralysis of the superior division of the facial nerve in hemiplegia from cerebral lesions is denied by many. Thus Landouzy says that in a large number of cases of facial paralysis in meningo-encephalitis the entire facial nerve was never affected; the orbicularis palpebrarum was never paralysed, and this, whether the facial paralysis was isolated or associated with hemiplegia. However, in a quite forgotten observation, published in 1873, Potain noted the impossibility of shutting the eye on the paralysed side in

hemiplegia without shutting the other, and Coingt, in 1878, whilst admitting that in hemiplegia, orbicular paralysis is never complete (as in peripheral facial paralysis) stated that there was a certain paresis of the orbicular, frontal, and corrugator supercilii muscles. Also, Berger asserted in 1879 that participation of the superior facial nerve was the rule, but that the paralysis diminished so rapidly that it was not perceived, if not looked for carefully. Byron Bramwell is of the same opinion. He says that the paralysis of the orbicularis may be complete at the beginning of intense hemiplegia, but that, like the conjugate deviation of the eyes, after a few hours it disappears.

Dr. Féré records a case in which what is very exceptional in hemiplegia occurred—persistence of marked signs of superior facial paralysis. The patient was a woman, aged thirty-six, who had suffered from convulsions in infancy with transient right hemiplegia. But ever since the right eye was incompletely shut during sleep. Signs of facial paresis were but little marked; the right labial commissure was slightly lowered. But the eye showed more marked traces of paralysis. When both eyes were open the right was the more gaping, and the lower lid was slightly everted. When shut the right eye was incompletely closed, and the sclerotic could be seen. This orbicular paralysis was therefore remarkable, not only in its persistence, but in its predominance.

Transverse Myelitis and Flaccid Paralysis. — M. Brissaud (*Progrès Médical*,

August 27) states that since the work of Charcot it has been generally admitted that secondary degeneration of the pyramidal tract, whether of spinal or cerebral origin, is always followed by spasmodic paralysis, with exaggeration of reflexes. This doctrine has, however, been controverted in the last few years by Bastian and others, who have related several cases of flaccid paraplegia with abolition of reflexes, in which there existed a secondary degeneration of the pyramidal tracts.

M. Brissaud relates the following case, which throws doubt on the conclusions of these writers:—A man, aged forty-one, who had contracted syphilis four years ago, complained of lumbar pains and difficulty in walking. As the symptoms became worse he entered hospital. He had all the signs of spasmodic paraplegia with exaggeration of patellar reflexes, muscular tremors, epileptoid trembling, paralysis of sphincters, &c. This state persisted for three or four months; then one day it was found that the paralysis had become flaccid and that the reflexes were abolished and that ankle-clonus was no longer obtainable. What was the reason of the transformation? The necropsy revealed it. At the level of the third

dorsal root a typical marginal meningo-myelitis, probably of infectious origin, was found. This sclerosis was equivalent to a veritable section of the cord. Above, the columns of Goll and Gowers and the cerebellar tract; below, the pyramidal tracts were degenerated. So far the case was contrary to the doctrine of Charcot. But changes were found in the anterior cornua in the peripheral nerves and in the muscles. The nerves were in fact destroyed, being the seat of typical peripheral neuritis. The reason why the spasmodic paralysis became flacid was, therefore, evident.

This case shows that to disprove the doctrine of Charcot it is necessary to make a complete examination of all the motor structures.

Thyroid Treatment.—A. Magnus Levy (*Zeitschrift für Klin. Med.*, Bd. 33, p. 258) gives the following conclusions derived:—(1) The loss of weight after the ingestion of thyroid is not due exclusively to loss of water and albumin, but in part, in some cases, to loss of fat. (2) So far as this is due to increase of normal tissue-change, it is moderate, except in myxœdema. Loss of weight, amounting to four or five kilos in a few weeks, is due to loss of water, albumin breakdown, and loss of fat from (pathologically) increased muscular activity, or later, from diminished consumption of food after long-continued administration. (3) Increase of metabolism does not occur in all persons who take thyroid. It is most marked in myxœdema; is evident, but much less so, in many cases of obesity, and in nervous women with masked Basedow's disease. Many fat but healthy persons show no elimination above normal. (4) The proteid deficit in thyroid feeding may continue even in case of superalimentation, and is, therefore, a specific effect of the substance. It is most marked in the beginning of treatment, and can diminish in consequence of habit or for other reasons.—*Amer. Jour. Med. Sciences.*

Lesion of the Conus Terminalis.—H. Labin (*Wien. Klin. Woch.*, 1898, No. 10) reports the following:—A man of fifty-five years fell from a wagon, a distance of about a mètre, striking on his back. At once he felt a severe pain in the back and was unable to rise. The whole body "felt as if dead." There was retention of the urine and fœces, lasting for five days. The paralysis lasted a week. Examination soon after showed no alteration in the eyes, no contraction of the visual fields, no pain in the spine, no atrophy nor loss of sensibility of the upper extremities, but loss of strength, increased reflexes, and in the deltoids fibrillary contractions. In the legs, passive motion was normal, the muscles were weak, the tendon reflexes much exaggerated, the plantar reflex was abolished, the cremasteric, abdominal, and other skin and mucous membrane reflexes were intact.

Sensation was preserved in all parts of the lower extremities, but there was a striking alteration of the temperature and pain senses. This was largely localised to both feet above the malleoli (higher on the right than on the left side), the middle and lower half of the lateral thirds of the calves, the lateral thirds of the thighs, the nates and sacral regions, the inner and middle gluteal, the anal, perineal, posterior scrotal regions, and all the surface of the penis. Hot and cold test-tubes could be recognised only by the touch, and differences of 5 to 15 deg. (Cent.?) could not be differentiated or localised. Sensibility to pain was absent in the same areas. Deep sensibility and sense of position was not affected, except as to the toes. During the patient's stay in hospital the motor power increased slightly, but sensibility remained unchanged. The author discusses at length the differential diagnosis, excluding hysteria, traumatic neurosis, syringomyelia, and inclines toward the diagnosis of hæmorrhage in the lower cord, with concussion of the upper cervical cord affecting especially the pyramidal tract. Special analysis is made of the probable nature and position of the lesion in the lower part, which the author believes to be central hæmatomyelia of the posterior horns of the lower lumbar and all the coccygeal cord. A useful list of articles bearing on the various points involved adds to the value of the paper.—*Amer. Jour. Med. Sciences.*

The Treatment of Articular Rheumatism by Local Applications of Salicylate of Methyl:—Siredey (*Jour. de Clin. et de Thér. Inf.*, Vol. V., No. 33).—The remedy is poured drop by drop upon the affected part, which has previously been washed and laid upon a rubber sheet. This is wrapped about the limb and covered with a flannel or gauze bandage. The dose is 50 to 120 drops, and its absorption is proved by chemical analysis of the urine within half an hour after the applications. The treatment may be repeated twice within twenty-four hours if the pain is very severe. No ill-effects have ever been noted upon the skin, and disagreeable general symptoms are extremely rare.

It is in sub-acute and chronic cases of rheumatism, which do not yield to salicylate of sodium, that the local method is particularly applicable, and in these it produces rapid and lasting good results. It is also very easily done. In the acute cases, where several joints are involved at the same time, the doses necessary for the several applications are very large, and the handling of the limbs is very painful. For these reasons the method is scarcely to be advised in acute cases, unless salicylic preparations cannot be taken internally. Cardiac complications in no way contra-indicate the local use of methyl salicylate.—*Arch. Pediatrics.*

Nocturnal Troubles of Children.—Dr. Lambert Ott (*Med. News*), contributes an article on what he terms the nocturnal manifestations of disease in children, though he qualifies the description by explaining that these are present by day also, though more apparent at night. When a child is restless, pale, irritable, with a capricious appetite, and must be coerced in order to get him to bestir himself, these symptoms may be due to (1) Thread, which should be cured by cold water salt injections repeated several times in one evening, as the first injection opens the bowels, and the others kill the worms.

(2.) Nocturnal hives to be cured by removing the cause, the use of gentle laxatives, and sponging with alcohol.

(3.) Night terrors, due to exciting tales told at bedtime, or sometimes caused by an elongated prepuce. Hygiene is sufficient to cure, and depressants such as the bromides are deprecated.

(4.) Nocturnal or unconscious masturbation, the child being sound asleep and not responsible. Circumcision is the cure.

(5.) Nocturnal enuresis. Circumcision is probably required.

(6.) Nocturnal drivelling is usually associated with renal inadequacy, and is to be cured by liberal administration of lemon-juice with sweet spirits of nitre, and by encouraging the child to drink large quantities of water.

New Drugs and Dermatology:—Cantrell (*American Journal, Dermatology*) reviews the list of recent drugs somewhat largely advocated primarily as substitutes for iodoform.

The first considered was DERMATOL, or bismuth salicylate, which has scarcely sustained the advantages claimed for it. In many cases it has not lessened, but rather increased, the discharge and inflammation, even to the point of acting as a caustic.

ALUMNOL is rather astringent in its action and notably efficacious in eczema, intertrigo, and acute dermatitis; non-parasitic sycosis, however, was cured in only one instance, while such contagious affections as impetigo, tinea versicolor, scabies, and pediculosis did not respond as quickly as with other remedies.

SALOL has given good results in the vesicular and pustular varieties of eczema, also in eczema rubrum and squamosum. In impetigo contagiosa and zoster, there was marked benefit, while the vegetable parasitic affections responded as follows:—Tinea circinata and tinea versicolor were cured; while tinea sycosis and tinea tonsurans were not influenced.

ACETANILID, one of the astringent group, is valuable where moisture or high grades of inflammation exist as complications. It is of service in all forms of eczema, and good results have been obtained in

instances occurring in silver and brass workers. In herpes zoster, syphilitic and non-syphilitic ulcerations, and in ringworm, good results followed its use.

SALICYLIC ACID is indicated as a stimulant in those cases where we hope to restore the normal functions of a part, as in eczema, with thickening and infiltration.

RESORCIN, which has similar properties, is of service where parasites have congregated, as in superficial ringworm.

SULPHUR and ICHTHYOL are both astringents, and are best employed wherever exudation (or denudation) is a constant symptom; as in eczema, all forms of acute dermatitis, cases where serum and pus are formed, and where a soothing or palliative effect is required.

BETANAPHTHOL was found to be an excellent stimulant in cases of acne and seborrhoea, alopecia and scabies.

IODOL, in the form of ointment, gave the best satisfaction of all of the iodine group in the treatment of ulcerations.

Antipyrin and Lactation:—Fieux (*Medical Chronicle*) remarks that for some years it has been noted that antipyrin has great effect in diminishing or checking after pains in women during the early days of puerperium. It has been thought, however, that antipyrin given to the nursing mother caused gastro-intestinal trouble in the infant. As the result of investigations Fieux concludes:—

(1) Antipyrin can be readily discovered in the milk. (2) Given in doses of fifteen grains each, at two hours' interval, it was discovered in the milk five, six, and eight hours after ingestion, and in some cases as long as eighteen hours. (3) The drug was found to be excreted very slowly, and was always in very small amount in the milk. (4) It had no influence on the quality of the milk. (5) It had no effect on the secretion of milk. (6) The infants showed no unfavourable symptoms. He believes that for checking the after pains it is better than opium.

Rumination in Man:—Sinkler (*Jour. Amer. Med. Assoc.*, April 9, 1898). Merycism, though described by ancient medical writers has attracted little attention of late years. Only thirteen cases are recorded in American medical literature; but, in European, a great number of cases have been noted. Merycism, or rumination, is not a simple regurgitation, or vomiting, of food, but is the return of food shortly after it has been ingested, unattended by nausea, retching, or disgust; in many instances, only those portions of the diet that demand remastication are returned. The regurgitated food is either ejected from the mouth, or remasticated, and again swallowed; and

it is a reflex act, controlled by a centre in the medulla. No constant anatomical lesion has been found. In the great majority of cases the condition is of neurotic origin, and it rarely occurs in healthy persons. Heredity plays a part in the causation of the disease, for Runge reports a case in which father, son, and grandson were merycoles. The prognosis is not good.

Treatment.—This consists mainly in attention to the general health of the patient. Lavage is an important procedure in cases in which rumination is dependant on indigestion. Hypnotic suggestion will probably prove useful, although there is no record of treatment by this measure.—*Cyclop. of Prac. Med.*

Extract of the Mammary Gland in Fibroid Tumours of the Uterus.*—

Dr. John B. Shober (*Med. News*) states that the results obtained by the employment of the thyroid gland in myxœdema and psoriasis, and by Dr. Robert Bell in primary carcinoma of the cervix uteri, show that it has a marked influence on epithelial structure. Diseases of the thyroid gland are often accompanied by excessive menorrhagia. The gland seems to influence the lining membrane of the uterus. Shober has successfully treated four cases of dysmenorrhea with menorrhagia in young, married, sterile women with small doses of thyroid gland.

The fact that fibroid tumours of the uterus are frequently associated with morbid glandular action and cystic degeneration may account for the successful results which have been obtained by the use of thyroid gland in a few cases. The possible value of mammary gland extract in the treatment of uterine fibroids is suggested by a paper by Dr. Robert Bell, of Glasgow, read at the meeting of the British Gynecological Society, 1896.

Shober reports the following results of this treatment :—

1. Mrs. W. White, aged thirty-two years, the mother of two children, consulted him, November 7, 1897. Menstruation was normal until after birth of her last child, three-and-a-half years ago, when she began to experience menorrhagia and dysmenorrhea. About two-and-a-half years ago she became conscious of an abdominal growth which increased rapidly in size. She suffered from increasing menorrhagia and metrorrhagia and all the associated symptoms.

The growth resembled a pregnancy near term. It was firmly fixed in the pelvis. The abdominal parietes were tightly stretched. She was very anæmic and extremely nervous. On December 14, at the end of a menstruation which had lasted two weeks, he ordered powdered extract

of mammary gland. Her next period began on January 2nd, and lasted only three days. It was free but not profuse. The tumour seemed to have contracted laterally. It had slight lateral mobility, and its surface felt irregular. The cervix had risen in the pelvis. Her next period was delayed eleven days, and lasted only three days. It was less free than at any time during the previous two years, and painless. The tumour diminished markedly in size.

Her general health has steadily improved. She is still under treatment.

3. M. D., coloured, aged thirty-three years; multinodular fibroid of the uterus.—Two small nodules were found on the left lateral wall near the fundus, and from the posterior aspect of the fundus arose an oblong, pedunculated fibroid, about four inches long and three inches broad. It could be felt rising above the pubes, and was freely movable from side to side. During the past two years her menstrual periods have been irregular and frequent, usually lasting only three days, but very painful and rather free. She began treatment November 27, 1897. She now menstruates regularly without pain, and her general health is improving. The two nodules on the left lateral wall of the uterus can no longer be demonstrated, and the pedunculated nodule is now one-half its original size.

The influence of mammary-gland products in the treatment of fibroid tumours of the uterus, as shown in these cases, is marked. These women are all under the age of thirty-five years, and, therefore, the menopause cannot be said to have had any influence upon the results which have been obtained. Without the aid of any other form of treatment the tumours are decreasing in size, and the general health of the patients is steadily improving. Under the influence of the drug menorrhagia and metrorrhagia cease, and the menstrual periods come on at regular intervals. The extract evidently has a powerful influence upon the uterine muscle or connective tissue, acting in a manner somewhat similar to ergot.—*Med. News.*

The Value of Hydrochloric Acid in Sciatica.—

A somewhat remarkable instance is recounted in the *Semaine Medicale* of a patient having arrived at the successful method of treatment for himself by the merest accident—an accident, too, which was founded on a blundering ignorance of chemistry. A man who had suffered for many years from sciatica was treated in an Algerian hospital by means of hypodermic injections of salt and water, but without much success. After he had left he bethought him that perhaps the salt was not strong enough, and that a stronger preparation of salt might be more successful. He therefore procured some "spirit of salt" (hydro-

* Read at the Twenty-third Annual Meeting of the American Gynecological Society, 1898.

chloric acid) and painted it on the skin, getting rid of his long-standing trouble in a few days. Having occasion, shortly afterward, to attend the hospital for some other affection, he confided in Dr. Bourlier, professor of therapeutics, whom he saw, how he had managed to get rid of his sciatica. This gentleman thought the plan worthy of trial, and employed it in several cases with invariable success. A thesis has recently been published on the subject by Dr. C. Gennatas, of Montpellier, on the basis of a dozen cases of neuralgia of the sciatic nerve, all of which were completely relieved by this means. The procedure is simple. Half an ounce of strong hydrochloric acid is put in a small cup, and applied with a brush over the painful part of the nerve, three or four coats being painted on. The limb is then enveloped in a cotton-wool dressing. The application causes a somewhat severe smarting sensation, but this is quite bearable. A few minutes afterward the skin becomes reddened and hot, and sometimes bullæ are formed, which fill with fluid. These, even if they occur, disappear in two or three days. Usually the patient feels better even after a single sitting. The application can be repeated in from twenty-four to forty-eight hours, but not again for several days for fear of producing sloughs. Where there are bullæ they must be avoided in subsequent applications. No serious inconvenience is caused by the hydrochloric acid such as was experienced when a similar procedure was attempted some years ago by Dr. Legroux with strong sulphuric acid, which was found to be liable to cause extensive sloughing of the skin. The patients referred to were all reported as cured in from three to five sittings, extending over from a week to twenty-five days.—*Lancet*.

Protargol in the Treatment of Gonorrhœa:—Dr. J. Barozzi, of Paris (*St. Louis Med and Surg. Jour.*, September, 1898), has published in the "Centralblatt für Dermatologie," the result of his experience of protargol in the treatment of gonorrhœa.

He states that he has found it superior to all the other anti-gonorrhœal remedies, and quotes largely from the reports of Professors Neisser and Haidoutoff.

According to Neisser, before commencing the injections, it is always necessary to determine the presence of gonococci in the urethra. In cases of the acute form of this affliction, he makes a minute examination of the pus coming from the anterior urethra, and in chronic cases he always takes the precaution to search for the gonococcus, in the discharge from the posterior urethra, by means of microscopical examinations, several times repeated. The injections should be made three times daily, and the fluid retained in the

urethra for a period of time varying from fifteen to thirty minutes.

At the end of several days the number of injections may be diminished, especially in cases where an amelioration of the local condition rapidly manifests itself, and in that event two, or even one, injection during the twenty-four hours will be sufficient. He considers it of great importance that the injections should never be discontinued until the disappearance of the gonococci has been positively determined by repeated microscopical examinations.

The strength of protargol solutions used in the initial stage vary according to the period of treatment. Neisser recommends aqueous solutions of 0.25 to 100 grammes; later he increases the strength to 0.5 grammes; and finally to 1.0 gramme per 100. Protargol solution 1 to 400 is not more irritating than a nitrate of silver solution of 1 to 4000.

M. Haidoutoff employed a solution of protargol of the strength of 1 to 1000 in twenty-one cases, thirteen of which suffered from acute urethral gonorrhœa, five from the sub-acute form, and three from the chronic form. In all he had recourse to abundant urethral irrigation, repeated once daily for a number of days, performed as follows:—

The patient, having emptied his bladder, is seated upon the edge of a chair, the body bent somewhat backward and firmly pressed against the back of the chair. Before commencing the irrigation, the glans, meatus, and prepuce should be cleaned with water and soap, followed by a weak antiseptic solution. The physician then introduces into the meatus a glass canula with a conical end (thoroughly disinfected) to which is fixed a rubber tube about two mètres long, attached to a glass receptacle, having a capacity of several litres, containing the protargol solution, and placed at a sufficient height to favour the flow of the fluid.

For washing out the anterior urethra it is important to hold the lips of the meatus tightly against the canula, in order to prevent the reflux of the liquid before complete distention, but as soon as this distention has been obtained the flow should be interrupted and the canula withdrawn. Repeat several times.

In washing out the posterior urethra, place the receptacle at a greater height, in order to overcome resistance. A height of 1.80 to 2 mètres is sufficient, but before passing the fluid into the bladder the glans and the anterior urethra should be carefully disinfected in the manner described. In the vast majority of cases the passage of the fluid into the posterior urethra and into the bladder is effected without difficulty; sometimes a certain amount of resistance is encountered, which, however, can always be overcome. It is exceptional

to meet with a case in which it is absolutely impossible for the fluid to pass.

After the fluid has reached the bladder in quantities varying from 150 to 300 gm., it is allowed to remain there for a few moments, after which the canula is withdrawn, and the patient expels the fluid. The same procedure is repeated twice, three times or four times, according to indications.

On the ground of the results obtained by Professor Neisser and M. Haidoutoff, the following conclusions may be formulated in regard to protargol :—

(1) It is an innocuous anti-gonorrhœal remedy, and possesses genuine antiseptic properties.

(2) It has the same curative effect as nitrate of silver, but possesses the advantage of giving rise to much less local reaction, and of never producing the symptoms of irritation for which nitrate of silver is occasionally responsible.

The Transmission of Contagious Diseases by Insects.—P. R. Joly (*Thèse de Bordeaux*), in a monograph on this subject, quotes instances of malignant pustule, Egyptian ophthalmia and Delhi boil conveyed by flies. He has also found, that the legs of flies may be covered by staphylococci and many other forms of bacteria. Tubercle is particularly liable to be disseminated by flies. They come in contact with sputa and other media, whereby the tubercle bacilli discharged from the body of the patient becomes ingested, and then alight on food and deposit the tubercle bacilli, and thus easily contaminate milk, meat, and other substances. The author quotes Yersin as having noticed that the bodies of dead flies collected in his laboratory often contained numbers of the plague bacillus. The influence of various insects, more particularly mosquitoes, in carrying the filaria sanguinis is well known. The mosquito has also been suspected as the agent in the conveyance of malaria.

The Medical Commission appointed to inquire into the cause of the severe epidemics of typhoid in the American camps during the war with Spain, reported that the disease was undoubtedly spread by flies, and that had it not been for these pests, there would have been only a few isolated cases.

Inebriety and Tuberculosis Allied Diseases.—Dr. T. D. Crothers (*Jour. Amer. Association*) maintains that in certain families tuberculosis and inebriety alternate; that a patient suffering from tubercle will take to drink, recover from his phthisis, and die of alcoholism; or, being addicted to drink in excess, will abstain, and shortly afterwards die of pulmonary disease. He claims that it will be found that these cases are indicative of race degeneration, and that heredity renders the subject liable to tubercle, alcoholism, and insanity. That the inheritance of low vitality

tends to the seeking of relief in stimulants, which still further reduces the vital forces, and thus invite the presence of the tubercle bacillus. Dr. Crothers suggests that, whilst paying so much attention to the transmission of the germs of tuberculosis, the neurotic condition of the tuberculous should not be overlooked. As Dr. Crothers does not say that his arguments are based upon observed facts, his deductions can have but little value.

The Treatment of Chronic Rheumatism with Hot Air (active Hyperæmia), and with passive Hyperæmia.—(*Ber. Münchener Medizinische Wochenschrift*, August 2, 1898. Professor Bier has tried the Tallerkau treatment for chronic rheumatism, and obtained good results, which he attributes to the active hyperæmia produced by the heat. Much more satisfactory, however, are the results of passive hyperæmia, produced by bandaging the limb above and below the affected joint. Pain diminishes, and stiffness yields; so that much greater mobility is obtained after the treatment. Taking the knee as an example: the leg and foot are first firmly bandaged up to a point a few inches below the knee, and an elastic bandage is then applied the same distance above it, over a simple bandage. The treatment is at first applied continuously, altering the position of the elastic bandage every twelve hours. Afterwards, it is left off either by day or night, and reapplied in the intervals.

Coloured Rings round a Flame.—(*Arch. d'Opt.*, May 1898). The occurrence of coloured rings of light has long been familiar as a symptom of glaucoma, under the name of the glaucoma halo or rainbow, and it is known also to be present in certain persons—as a physiological peculiarity. Druault is one of these, and he records the results of his investigation of his own unusual condition, which he has studied with much care.

The ring or halo is best (or only) seen when the pupil is dilated; it presents more or less distinctly all the colours of the spectrum, green as a rule predominating, and has a striated aspect, the striæ being radially placed. It may be seen either by dilating the pupil artificially, or by looking at a distant small point of light in a dark room; placing the light in front of a dark background, and some distance before it, brings out the phenomenon best. The colours are arranged as in the rainbow, blue and green nearer the flame, red to the outside; when the light is very feeble one only sees green, the other colours not appearing; yellow is only visible if the colours are particularly vivid. It is a notable feature, too, that the intensity of the colours is not uniform all round the circle, but varies at different points; where the brightness is greater, radial striation may be distinctly seen. The actual size of the

halo depends, of course, upon the distance to which it is projected, but the extremities of one of the diameters are always seen under the same angle by the same person; and it is curious to observe, too, that the dimensions vary but little between one person and another.

A very singular feature of these rings is seen on passing a screen or card in front of the eye: say that a card is passed horizontally (with a vertical edge) between the observing eye and the light. As it advances, two segments of the circle, a right and a left, begin to disappear, the upper and lower remain till the last, diminishing in size more and more as the pupil is gradually covered: this fact has been known for many years. It might be supposed that since mydriasis is necessary for the manifestation of these rings, they would be invisible through a pinhole or other very small aperture; but it is found that, though that is the case when the aperture is opposite the centre, it is not so if it be held at one edge of the enlarged pupil. In such a case a circle of diffusion is seen with the light to one side of the area, and two small portions of the halo are visible outside of, but close to, the border of the circle of diffusion, at two extremities of a line passing through the luminous point. If one moves the card so that the aperture describes a circle all round the periphery of the pupil, each portion of a halo will also be found to describe such a circle. It is sometimes possible, when working with the pinhole aperture, and a very small and bright luminous point, to perceive portions of a double circle. Druault has no doubt that it is a diffraction phenomenon, due to the crystalline lens, which is only produced peripherally; the central portions are not apt to cause it. He has experimented with the lenses extracted from the eyes of the horse, rabbit, ox, sheep, and pig, and in some of these animals was able to show the condition by passing light through the lens in the laboratory, but not in all.—*Edinburgh Med. Jour.*

Iodine as a Test for Bile:—Rosin (*Wien. Klin. Woch.*, 1898, No. 11) calls attention again to the use of iodine as a test for bile. The re-agent is a dilute tincture of iodine, of a bright mahogany colour. The test is made by allowing the iodine to run into an inclined test-tube containing the suspected fluid, and in the presence of bile forms a grass-green ring at the point of contact.

Venesection and Intravenous Infusion in Opium Poisoning.—A man (*Med. News*, August 14, 1897) was admitted to the Presbyterian Hospital, New York, with a history of having swallowed two ounces of laudanum two hours before. The patient was intensely cyanotic, and could not be awakened. The pupils were minutely contracted. The respirations were reduced to nine in five

minutes, laboured, and stertorous. All the ordinary methods of treatment were tried and, after three hours of useless work, it was suggested that, since a large amount of the drug had probably been taken up and absorbed by the blood, if some of the blood could be removed and a pure circulating medium take its place, good results might follow. Accordingly, twenty-five ounces of blood were removed by venesection and one and one-half pints of normal salt solution introduced. Favourable symptoms quickly appeared, and forty-eight hours later the patient was discharged.

Bactericidal Action of Boracic Acid on the Infective Agents of Cystitis:—M. Botaski (*La Presse Med.*, June 29, 1898) has recorded his experiments on the inhibitory action of urine on germ life.

He found that healthy urine but feebly influenced the multiplication of the colli-bacilli, but when the acidity of the urine was intensified by administering boracic acid the germ was promptly destroyed and disappeared from the urine.

The Opium-Bromide Treatment of Epilepsy.—Th. Ziehen (*Therapeut. Monatshefte*, August, 1898), makes the following observations relative to Flechsig's opium-bromide treatment of epilepsy, introduced in 1893: When the diagnosis is certain, the only contraindications are great debility or serious heart disease. He has observed several cases in which Flechsig's treatment caused great and lasting improvement where bromides alone had failed. The course begins with the administration of opium.—For an adult, $\frac{3}{4}$ -grain three times a day, gradually increased up to 13 or 14 grains in the twenty-four hours, the maximum dose to be reached in seven weeks, usually, though it may take three months.—Diet is of equal importance. All spices, alcohol, coffee, tea, and beef-tea (including bouillon, soups, &c.), are absolutely prohibited. One meat meal a day is allowed; smoking and sexual intercourse are forbidden; rest of body and mind are indispensable. A simultaneous cold water course is advantageous. The author has never seen any dangerous symptoms, but the pulse rate may fall to 40 beats a minute, and the temperature to 96 deg. F. The appetite may fail, and constipation be troublesome. The former can be improved by dilute hydrochloric acid after meals, and the latter by change of diet and massage. The patient usually loses weight. The fits diminish in frequency or intensity in about a third of the cases. In half no difference is observable, and a few become worse. Ziehen agrees with Flechsig that it is best to leave off the opium suddenly, and to replace it at once by $1\frac{1}{2}$ to 2 drachms of bro-

mide. At this time absolute rest in bed and a competent nurse are required. The temperature and pulse must be taken every two hours. The temperature and pulse rate rise, as a rule, very quickly after the opium is left off, the pulse reaching 120 on the slightest excitement. The state of the heart has never given Ziehen real anxiety. Diarrhoea is common, but is usually replaced by constipation in a few days. The appetite improves, and the patients gain weight. Muscular restlessness is often very troublesome. The bromide should be given in as large a dose as possible for at least a year, and only then left off if there have been no fits for some time. It is best to lessen the dose gradually. However, the occurrence of bromism often compels one to omit the treatment for some time. The bromide treatment constitutes the chief danger of the whole course, but this applies equally to the usual bromide treatment without opium. Heart failure, bronchial catarrh, or bronchopneumonia, and a whole series of dangerous or unpleasant symptoms may be met with. Ziehen thinks the absence of the corneal reflex to be the best warning to reduce the dose. The diet should be the same as it was during the opium course. Rest in bed for the first three to five days is necessary, or even for a longer period. The patient should get up at first for only two hours a day, but this can be increased. Exercise must be taken with caution.

A Symptom of Facial Paralysis.—Drs. Bordier and Frenkel (*Le Scalpel*) have noted a new phenomenon in peripheral facial paralysis, which has considerable prognostic value. This is the rotation of the ocular globe from above downwards during the act of closing the eyelids. Bonnier says he has encountered this sign in all cases that he has observed. Frenkel and Bordier explain it as an actual nervous discharge. Dr. Bonnier thinks that it is a simple derangement in moticity.

PARL. KLIN. WCHMSCHR.

Acute Epidemic Ophthalmia.—Hardly a year passes by, says Greeff (*Berlin Klin. Wochs.*, May, 1898) without an outbreak of acute Egyptian ophthalmia. No district is quite free, and each year acute ophthalmia makes its presence felt in or about Berlin. In the early Napoleonic time, Egyptian ophthalmia is said to have destroyed the sight of many hundreds in a few days. In pursuance of orders from Government, Greeff has had good opportunity to study carefully true trachoma in regions where it is very common, and also one such epidemic in a district hitherto free. He discusses the features of certain epidemic ophthalmias which, though often confounded with trachoma or Egyptian ophthalmia, are really distinct. The mode of outbreak is not like that of

trachoma, which does not spread so rapidly; trachoma is no doubt contagious, but every contagious ophthalmia is not trachoma. The contagious character of trachoma shows itself rather in the slow invasion of the other members of a family or household, of whom one or more has been affected for years, and this usually in a country or district where the disease has been endemic for a century, or it may be for ten centuries. He contrasts certain forms of conjunctivitis with one another and with trachoma.

1. *Pneumococcus Conjunctivitis.*—The pneumococcus (Fränkel - Weichselbaum) occurs as an occasional inhabitant of the normal conjunctiva, and it may increase so as to bring about an epidemic. It is generally children it attacks; adults are but rarely affected. It is a transient malady, running a benign course somewhat quickly; there is a slight œdema of the lids, and there is a free lachrymal or muco-lachrymal secretion. Giffard has succeeded in cultivating the pneumococcus from the discharge from inflamed conjunctivæ during an epidemic, and producing the disease by planting in other sacs.

2. *Morax and Axenfeld's diplo-bacillary conjunctivitis.*—This is a more chronic variety, in which the lids participate largely. In cover-glass preparations the germs are very numerous, lying for the most part in pairs, less frequently in chains. Implantation upon normal conjunctiva produces typical conjunctivitis. It is not certain that any epidemic of this has actually occurred.

3. *The conjunctivitis of the Koch-Weeks bacillus.*—This seems to be the most frequent of the contagious conjunctivites. When in Egypt, Koch found the germ in cases of the slightest form of so-called Egyptian ophthalmia. It is the cause of acute contagious (epidemic) conjunctivitis. It sets in very rapidly; within two or three days the conjunctiva is strongly reddened, the lids swollen, and an abundant serous exudation begins, which after a few days becomes purulent. Both eyes are usually affected; pain, lachrymation, photophobia, and a sense of burning are complained of. The inflammation lasts about two weeks, and the prognosis is uniformly good.

These are the ordinary forms of contagious conjunctivitis. The gonorrhœal form (with Neisser's bacillus) and streptococcus conjunctivitis require mere mention. Some hold, too, that phlyctenular conjunctivitis is of bacterial origin. As regards the bacterial origin of trachoma there is nothing settled; whether a diplobacillus or *Bacillus septatus* is the cause is not certain. In case of an epidemic conjunctivitis arising, it is possible to make a diagnosis of its true nature by examination for micro-organisms. Sometimes it happens that the medical officer of a school makes the alarming discovery that a great number of the scholars are suffering from folli-

cular enlargement, and he may find it necessary to close the institution. He must be careful not to be misled by an epidemic follicular catarrh, or, to be more accurate, follicular swelling. Schmidt-Rimpler, while engaged in the study of the cause of the frequency of short-sightedness in schools, noticed that many children suffered from some affection of the conjunctiva, and decided to make inquiries as to the frequency of catarrh, &c., at a time when there was no epidemic: he found a percentage of 34. On investigation, Greeff finds follicles in 27 per cent. of the children. Even if this be an exaggerated estimate, it indicates that upon the mere discovery of follicles along with epidemic conjunctivitis, one must not say, "Here is Egyptian ophthalmia." But to what are these follicles due? The author, with others, believes them to be due not to contagion, but to a general pathological condition; they are quite common in anæmic girls whose conjunctivæ are not in the least inflamed. Prolonged fomentation of the eye (as in the treatment of iritis, &c.) will produce them also. The difference between them and trachoma granules is an essential difference.—*Edinburgh Med. Jour.*

Ameboid Bodies in the Blood of Vaccinated Subjects and in Cases of Variola.—Surgeon Walter Reed, U.S.A. (*Jour. of Exper. Med.*), confirms the observation that small granular ameboid bodies are present in the blood of vaccinated children and calves, and in that from cases of variola during the stage of fever. Nuclei in any of these bodies could not be positively made out. Similar granular ameboid bodies, having a diameter about one-third that of a red blood-cell, were also found in the blood of monkeys during the active stage of vaccination, disappearing with the decline of the local inflammation. A body of like appearance, granulation, and size was occasionally found in the normal blood of monkeys and children. Pale ameboid bodies, containing a few dark, pigment-like granules, were found in the blood from cases of variola and in that of a variolated monkey.—*Med. Record.*

The Electrical Treatment of Neurasthenia in Hysterical Patients.—Apostoli and Planet (*Annales d'Electrobiol.*, May 15, 1898) in a second communication, record four cases treated by electricity. They state that these two neuroses are frequently found in association in the same subject, though in different degrees. Neurasthenic patients, who are also hysterical, often derive great benefit from treatment by static electricity. The curative process of the static bath is especially exercised upon insomnia, and its effect is marked by the return of normal sleep. Most, but not all hysterical patients, whose condition is improved

by static electricity, show an intolerance varying in degree, towards the high frequency currents, and especially towards auto-conduction in the electric cage. Faradisation, which is, as a rule, indicated as alone serving to produce an effect upon certain local hysterical troubles, especially those of sensibility in one organ or a limited region, is often powerless, while static electricity, which acts in a general manner, may give more rapid and more effectual results. Static electricity, can, indeed, according to the authors, bring about the disappearance of certain hysterical manifestations, such as convulsive tics complicated with constipation and copremia. Finally, the authors state that static electricity or franklinisation (consisting of a simple bath, with electrodes leading off from the vertebral column and the painful points), is the most efficacious electrical means of rendering aid in the treatment of a considerable number of hysterical patients.

Diabetic Coma.—Dr. Thomas Oliver (*The Lancet*, Aug. 13) reports a case successfully treated by saline transfusion. No relapse four weeks afterwards. The solution was composed of a drachm of chloride of sodium to a pint of boiled distilled water. Two-and-a-half-pints at 112 deg. F. were passed slowly into the median basilic vein. The patient regained consciousness during the operation.

Dangers of Blisters.—Dr. Huchard (*Bull. de l'Acad. de Méd.*, No 7, 1898) states concerning blisters:—

(1) They often produce an open wound which facilitates secondary infections or the absorption of cantharides.

(2) Besides tending to cause inflammation of the kidneys and bladder, they have a general congestive action.

(3) Even in those diseases where they are most frequently used, such as pneumonia and pleurisy, they should be discarded, as they increase pulmonary congestion.

(4) Blisters tend to arrest excretion by the kidneys, so important in all infectious diseases, and this is especially harmful in those normally causing albuminuria. Instead of aiding the excretion of toxins, blisters are likely to produce a fresh intoxication.

(5) The only real use of blisters is in their revulsive and analgesic action, but the effect is better attained by less dangerous means, such as mustard plasters or cold baths.—

Carcinoma of the Duodenum.—Schlesinger (*Wien. Klin. Woch.*, 1898, No. 10) found carcinoma of the duodenum in a woman aged fifty-eight. Symptoms began a year before, with vague pain in the hepatic region. The patient became jaundiced; later the liver became enlarged, and the gall-bladder distended. In the last week

bilious vomiting often occurred at night; the stools, clay-coloured before, showed traces of bile-colouring matter; the jaundice was intense. There were no signs of stenosis of the intestine; the stomach contents were never alkaline. Necropsy showed a cancer of the descending duodenum, extending to the diverticulum of Vater, with bending of the cystic duct, and dropsy of the gall-bladder. The absence of stenotic symptoms is interesting. Out of 42,000 necropsies in the Vienna Pathological Institute (1870-1893) there were only seven of cancer of the duodenum. Of the whole number there were 3,583 cancers, 443 being intestinal.—*Amer. Jour. Med. Sciences.*

Jaundice in Typhoid Fever (*Lancet*).

—Jaundice is a very rare complication of typhoid fever. The *American Journal of Medical Sciences*, July, 1898, contains an exhaustive paper by Dr. Da Costa on this subject. Jaundice does not usually come on until the middle of or until late in the disease, but it may come on as early as the incubation period. The stools are much like the ordinary typhoid; very rarely clay-coloured. The liver is usually tender. Parotitis has been observed in a number of cases. The jaundice is of the toxæmic form, and seldom depends on obstruction (in the ordinary sense). The prognosis is grave: thirty-three deaths occurred in fifty-two cases. Atrophic cirrhosis was a sequel in one.

The Treatment of Hepatic Abscess.—

Surgeon-Lieut.-Col. Hatch, F.R.C.S. (*Indian Medical Gazette*, Aug.)—Early operation is important. This is shown by the difference in mortality of hospital and private practice. In the former the cases come under treatment when the disease is advanced and the mortality varies from 30 to 70 per cent.; in the latter they are seen earlier, and the mortality is only 20 per cent. The so-called tropical abscess may develop in less than a month, but it usually takes two or three.

With the exception, perhaps, of bulging and fluctuation, no signs are diagnostic. Œdema usually signifies suppuration, but when it occurs the first two symptoms are also present. In several cases the writer has noticed a strong hepatic odour exhaled from the patient. Pyrexia may be absent.

Aspiration is attended with risk of serious and even fatal hæmorrhage, and this risk is perhaps greatest in cases where there is no abscess. The writer would use the needle as little as possible for the purpose of diagnosis, and more with the object of locating the abscess when feeling certain of its presence. When the enlargement is epigastric aspiration is specially dangerous, and he prefers to open the abdomen through the fibres of the rectus muscle and expose the liver. Bulging may then be de-

tected with the finger. A small trochar and canula may be introduced at various points, and if bleeding is excessive, it can readily be stopped by pressure. If pus is found, an incision is made by the side of the canula and a drainage tube is introduced. He never stitches the liver to the parietes, as that is unnecessary, for he has never known pus to escape into the peritoneal cavity.

On Megrim and its Treatment.—Dr. Frieser (*Münch. Med. Woch.*, No. 35, p. 1121) states that:—

“Attacks occur periodically after longer or shorter intervals, and vary in intensity. The patients feel poorly for some time beforehand, and know that an attack is coming, so that we can speak of an aura preceding the onset. The headache is generally confined to one side of the head, and increases in intensity, till at last the patient lies motionless with closed eyes dreading the least sound that may add to his misery. Many patients complain, before the attack occurs, of a weakness in the eyelids, so that they are only closed with an effort; flashes of light before the eyes are also common. Nausea and vomiting almost always accompany the attack, which lasts one to three or more hours, sometimes even twenty-four to thirty-six hours, during which time the pain varies in intensity. Restlessness at night and even delirium occur, so that the use of morphia may be necessary. Appetite fails and the patient feels feverish, the pulse may be either increased or diminished in frequency, and the tension of the radial artery raised. Actual rise of temperature is, however, rare, and its occurrence suggests some further trouble than megrim alone. Vomiting generally occurs once or more in last attack, and often appears to afford relief to the sufferer. The pupils may be dilated or contracted, but re-act normally to light.”

Since decomposition of food in the stomach, and consequent ptomaine poisoning, are the principal exciting causes of the disease, it is to the digestion that the greatest attention must be paid. All food liable to fermentation must be avoided. Tea, coffee, and acid fruits are to be forbidden, and cheese, butter, and rich dishes avoided as far as possible. In severe cases of gastric dilatation even milk must be withheld, and koumiss substituted. Washing out the stomach, or if that is refused, copious draughts of hot water are very beneficial. Of drugs menthol may be used, and the valerianat of menthol is a good form in which to administer it. (R. Menthol. valerianat, 5 grm. Aq. destill. 25 cc. Syr. Capillor Vener 30 cc. Fifteen drops of the mixture to be taken every two hours). In anæmic patients iron tonics to be given, such as ferratin, or iron and quinine. Somatose is beneficial in emaciated cases. The bowels must be carefully attended to, preferably by means of enemata; if these are refused, by extract of cascara

sagrada and tincture of rhubarb. Saline aperients are also useful. Antipyrine, phenacitin, anti-fibrin, sulphur, pald, and lactophenin are not generally of much use, but benjacerin and tripherin in 0.5 gm. doses seem at times to do good. In cases with contracted pupils caffeine citrate is indicated—*i.e.*, those with dilated pupils a few drops of ether may be used as an inhalation. Even after apparent cure relapses are liable to occur, and may be provoked by excessive mental disturbance.

Spinal Rheumatism.—Weisz (*Wiener Med. Presse*, No. 33, 1898) quotes statistics showing the frequency of rheumatism of the spinal column and its adnexa. Werichmann, from subacute and chronic cases only, concluded that the joints of the vertebral column (including the neck) were more often affected than any others (in 87 per cent. of all cases). Dulberg and Stoll give the figure for acute cases as 5 to 10 per cent. The difference may be explained by the fact that in acute polyarticular rheumatism the spine is very seldom examined. It is important to be able to tell whether the joints, tendons, muscles, or fascia are affected, and the following are useful guides to diagnosis. (1) If the pain is spontaneous and not increased by movement it is probably not a rheumatic spinal complaint at all; (2) if the pain remains unchanged during passive, but increases during active movements, the trouble is most likely in the muscles, tendon-sheaths, or fascia. (3) When active and passive movements cause equal pain the joints alone are probably at fault.

The treatment depends on the case. If chronic, rest may do more harm than good, and anti-rheumatic drugs are of little or no use. They must then be replaced by systematic exercises, massage, and warm baths. Pain is often relieved by the galvanic anode.

Dural Injections.—Since Quinke, in 1891, published his report on Lumbar Puncture, it has been widely practised, and has proved very useful as a diagnostic measure, though its therapeutic results, especially in lessening signs of cerebral pressure, have been somewhat disappointing. Paul Jacob, at the recent "Congress for Internal Medicine," at Wiesbaden (*Therapeut. Monatshefte*, August, 1898), stated that he had experimented by injecting a 0.1 per cent. solution of Na Cl into the subarachnoid space of dogs, and that even large quantities, such as 70 c.c., produced no pressure symptoms whatever. He concluded, therefore, that a simple increase of the amount of cerebro-spinal fluid is not in itself sufficient to produce symptoms of pressure, and that improvement in such symptoms is not to be expected from lumbar puncture. In a second series of experiments Jacob used injections

("dural infusions") as a means either of washing out the subarachnoid space in different forms of meningitis, using a 0.1 sodium chloride, or 0.5-1 per cent. carbolic acid solutions, or of acting directly on the meninges by solutions of drugs, such as iodide of potassium.

Eudermol in the Treatment of Scabies.

—Max Wolters (*Therapeut. Monatshefte*, August, 1898) recommends eudermol, which is a salicylate of nicotine, in the treatment of scabies. After a bath in soap and water a 0.1 per cent. lanolin ointment cured the itching permanently in sixty-four out of sixty-seven cases. The remaining three required six applications. The advantages of eudermol over other drugs commonly employed are that the 0.1 per cent. ointment is not irritating, and does not cause albuminuria or poisoning. Strong solutions, such as 5 per cent., which are quite unnecessary, may produce intoxication in young children, and should therefore be avoided. Eudermol is almost odourless, and soluble in water.

Glycosuria in Cholelithiasis (*Exner. Deutsch. Med. Woch.*, No. 31, p. 491).—Of forty cases of gall-stones, the existence of which was verified by operation, in only one was no trace of sugar found in the urine. After the removal of the stones, the copper reducing substance entirely disappeared. The presence or absence of jaundice in the patient appeared to make no difference.

Membranous Tracheitis and Laryngitis without Diphtheria Bacilli.—L. A. Grimes, M.R.C.S., L.R.C.P.—(*The Lancet*, Aug. 13). A boy aged four years, recovering from an attack of measles, was admitted to St. George's Hospital with marked stridor, and recession of the episternal notch and lower thorax during inspiration. The tonsils were slightly injected. The symptoms became worse, and tracheotomy was performed. When the tube was inserted, a large piece of greyish-yellow, very tough membrane was coughed up. Dr. Ewart's method of introducing creosoted oil, 1 in 20, into the trachea, was at once adopted. Five minims every two hours softened the membrane, and enabled it to be coughed up. Bacteriological examinations made on several occasions showed numerous bacilli, but none of diphtheria. The child recovered.

Acute Myositis.—Bertelsmann (*Münchener Med. Wochenschr.*, August 9, 1898) reports the case of a youth, aged eighteen, who twice since 1891 had had attacks of pain in the calves, followed by swellings, which subsided spontaneously. While in Rumpel's clinic, from April 1 to July 21, 1898, seven of these swellings appeared from time to time in the substance of different muscles. The nodules were mostly about the size of a small

walnut, hard, movable with the muscle, roundish but spindle-shaped at the upper and lower poles, and very tender. One in the extensor carpi radialis longior was exposed by an incision, under Schleich's anaesthesia. It was the size of a hazel-nut, and of a mottled colour, the interstitial substance being greyish white, the muscular bright red. A piece removed for microscopic examination showed that the inflammation was partly interstitial, there being abundant round cells and fibrin exuded, and partly parenchymatous, the fibres being swollen and the cross striation blurred. The nature of these nodules is uncertain, but their appearance is always preceded by so-called "rheumatic" pain, in this case unaccompanied by fever. If they persist for long they may become fibrous. Here evaporating lotions had no effect but salicylate of sodium caused most to disappear totally in forty-eight hours.

It may be mentioned that the patient had signs of phthisis at both apices, though tubercle bacilli were not discovered.

"A new form of Parasite in an Empyema."—Welcke (*Münch. Med. Woch.*, No. 34, p. 1088). Dr. Welcke discovered, in the pus of an empyema, a number of thread-like organisms, 100–140 m. in length, some of which presented a definite oval thickening near one end. Stained specimens showed forms resembling in shape (to judge from the illustration) small nematode worms. Professor Hertwig considered that the thread-like forms were to be classed with the spirilla, while the others, which showed a nodular thickening, were intermediate between spirilla and protozoa. Dr. Welcke noticed a resemblance in the living specimens, which exhibited active lashing movements, to a parasite described in Leukart's work as *Cercomonas intestinalis*. According to Loew and Hofer, parasites similar to those here described are met with in the insect kingdom.

The Pathology and Treatment of a Fit of Gout.—Dr. George Balfour (*The Lancet*, Aug. 13) believes that all the objective phenomena of a gouty paroxysm are readily explicable on the supposition of a stasis in capillaries of the affected joint, and that they are not the result of inflammation. For, though there be moderate pyrexia 100–102 deg. F., the temperature of the extremity of the affected toe is always sub-normal, 95.5–97 deg. He quotes the statements of many writers to the effect that a threatened attack of gout may be warded off by exercise. As a method of treatment massage is little mentioned in literature, but Boerhave speaks of it. Cullen records the case of a man confined to bed with gout who rose and ran as fast as he could when he heard that his neighbour's house was on fire,

and was quickly cured. At the beginning of the century Dr. William Balfour, of Edinburgh, had a great reputation for the treatment of rheumatic affections by massage. Occasionally he attacked more acute ailments with a boldness and success which were remarkable. He relates several cases of acute gout treated by compression, friction, and percussion.

The Treatment of Elephantiasis by Electricity (*Lancet*).—In *La France Médicale*, July 24, 1898, Dr. Albert Weil has published a case of elephantiasis in which a remarkable result was obtained by galvanism. An obese washerwoman suffered from extreme elephantiasis of the legs. The left measured in circumference 57 and the right 55 centimetres, and the patient weighed 128 kilogrammes. Bandages proved useless. A constant current was applied to the left leg. Two metallic electrodes covered with chamois-leather, measuring 16 by 26 centimetres bent into half-cylinders, were applied to the leg and connected with the negative pole. The positive electrode, which was 10 by 26 centimetres, was placed on the nape of the neck. A current of 20 milliampères was passed for quarter of an hour, and the leg was then compressed with a bandage. The right leg was similarly bandaged. The treatment was repeated at intervals of two or three days with currents ranging up to 50 or 60 milliampères. On the thirty-third day the left leg measured 45 centimetres when elastic bandages were substituted for the cotton ones. Both legs were then galvanised and reduced to 38 and 40 centimetres, and the patient was practically cured.

Ointments of Salicylic Acid and Ichthyol in Acute Rheumatism.—Arendt (*Ann. et Bull. Soc. de Méd. d'Anvers*, April, 1898) draws attention to the value of salicylic acid ointment in acute rheumatism. Ruel, Bourget, Ziemssen, Sterling, and others have already testified in favour of this treatment, and Unna, Ritter, and Ingra have shown that while salicylic acid is freely absorbed by the skin, salicylate of sodium is not so. The best basis for absorption is an ointment composed of lard and lanolin, and Arendt finds the following formula the most suitable:—R. Acid. salicylic., ol. terebinth., lanolin, aa. $\frac{1}{2}$ oz.; adipis, ad 3 oz. This ointment is spread on a cloth and applied to the joint, being then carefully and completely enveloped in gutta-percha and a flannel bandage. Absorption seems to take place best when the parts are bathed in perspiration, and in persons with thin transparent skin. The usual physiological effects of the salicylates are manifested (singing in ears, perspiration, &c.) in a very short time, but the gastro-intestinal troubles, so often observed after they are taken by the mouth, are always absent. Arendt states that he has

treated many cases by epidermic applications alone, and that they have all done well, although the dose is smaller than that usually given by the mouth.

In chronic rheumatism and gout, improvement often occurs after local application of the ointment is continued for some time. In such cases Arendt uses the following—R. Acid. salicylic., 300 grs.; spt. rectif., 3 oz.; ol. ricini, 6 oz.—*M.* Lint is soaked in this, and, covered with gutta-percha and wadding, is kept applied over the joints. The swellings and nodosities often disappear entirely under its continued application. The advantages of this method are—(1) The dose is smaller, and acts just as efficaciously. Absorption is, however, uncertain, but probably not more so than when salicylates are given by the mouth. (2) The stomach is spared, as a rule, although not always.

Arendt has also used ichthyol (ammonium ichthyolate) largely, as an external application to rheumatic and gouty joints, either alone or in conjunction with salicylates given internally. It has, in acute cases, a marked analgesic effect, and not only the pain, but the swelling, disappears from the first application onwards. In chronic cases its effects are much less marked. He uses the following—R. Ichthyol, aq. destill., aa. 3 drms.; lanolin, 1 oz.—*M.* Or what is, on the whole, better, and not so fluid—R. Ichthyol, $\frac{1}{2}$ oz.; extr. belladon., 22 grs.; lanolin, 1 oz.—*M.* Ft. ungt. Or, R. Ichthyol, spt. rect., aa. 3 drms.; aquæ, 12 drms.—*M.* Ft. linimentum. This last forms a sort of varnish, which can be washed off with water if necessary. It is applied twice daily, and it is always necessary to carefully wrap up the joint. Ichthyol is not so active as salicylic acid, but it forms a good adjuvant to salicylates given internally, and a good substitute where they are not well borne.—*Edinburgh Med. Jour.*

The Frequency of Gall Stones in cases of Mitral Stenosis.—Dr. E. M. Brockbank (*Edinburgh Med. Jour.*, July) calls attention to a curious fact in pathology—the frequency of the occurrence of gall stones in the subjects of heart disease, and particularly of mitral stenosis. In 1347 necropsies, at the Manchester Royal Infirmary, Dr. Kelynack paid special attention to the condition of the gall bladder. Gall stones were found in 7.4 per cent., but in cases of marked heart disease the proportion was 10.9 per cent., and in cases of mitral stenosis it was 21.8. During life, however, it is very unusual to find symptoms indicative of gall stones in the subjects of mitral stenosis, or other cardiac lesions.

Post-mortem examination of the bile, in several cases of heart disease, show it to be full of desquamated cells, mixed with a few cholesterolin crystals. After some days the cells disappear, and the cholesterolin crystals appear in greater numbers,

until finally no traces of cells remain, and the bile is full of crystals in innumerable profusion. A tendency of the biliary mucous membrane to produce an abnormal amount of cholesterolin appears to exist. The lowered vitality of the system, and the passive congestion of the mucous membrane no doubt are the causes of this. Such appears to be the pathogenesis of these calculi.

The Treatment of Xanthoma by Mono-Chlor-Acetic Acid.—Nearly all authorities agree that excision is the only treatment of xanthoma. Stern has reported several cases cured by the use of 10 per cent. sublimate solution, and Morrow one cured by 25 per cent. salicylic acid plaster. Dr. James McGuire reports several cases cured by mono-chlor-acetic, a caustic which has not been used before. A woman had typical patches on the eyelids, of four years' duration. Those on the lower lids were about the size of split peas, and even with the skin; those on the upper were elevated and larger. Electrolysis was employed without perceptible result. Mono-chlor-acetic was applied to all the patches, but to only part of each lesion at a time. The growths completely disappeared; in six weeks there was no sign of the disease, but the skin was slightly lighter in colour than the surrounding.

The Education of the Sense of Smell.—Dr. Benedict (*Medical News*, August 20) finds that the sense of smell is but rarely cultivated: not 1 in 50 persons has the power of distinguishing individuals by this sense. Some have described the odour as usually agreeable and often, in the case of the opposite sex, as an excitant of passion. It is impossible for anyone to keep inodourously clean. The following odours may be detected singly or combined:—(1) Neglected skin secretion, sebaceous or sudoriparous; (2) the special odour of the axilla; (3) the special odour of the smegma; (4) the special odour of the perineum; (5) the special odour of the scalp; (6) the odour of the breath; (7) menstrual blood; (8) the odour of the feet; (9) drugs excreted by the skin. Owing to personal differences in chemistry, some may remain free from odour while careless as to bathing; whilst others cannot by the greatest care counteract a tendency to bromidrosis. After diarrhoea a characteristic saline (?) and not disagreeable odour may indicate the loss of serum or mucus. Phthisical patients are apt to develop a peculiar sour odour of the breath, especially after cavities have formed. The odour of mercurial stomatitis is described as characteristic, but personally, the writer cannot distinguish it from the odour of noma or other extensive ulceration or of necrosis. Sour eructations do not usually produce more than a temporary odour of the breath, but the same bacterial process is likely to take place in the mouth. Gangrene of the lungs

has a characteristic odour. In diabetes, not only the breath, but all secretions may be perfumed with what was formerly supposed to be acetone. The odour of chronic alcoholism is quite different from that of recent drinking. In very few instances is there a characteristic odour diagnostic of disease—favus and variola are examples.

Problems in toxicology are often solved by the sense of smell. Dr. Benedict sounds a note of warning. A man was convicted of murder, mainly on the testimony of a physician who gave a death certificate of natural causes, but whose suspicions were afterwards aroused. He made a necropsy several days after death, and the body had been embalmed. From the odour of the brain he made a positive diagnosis of hydrocyanic poisoning. Dr. Benedict thinks that, as the brain has normally a peculiar odour, which may be described as spicy, and as that physician did not make many necropsies, one may be pardoned for doubting whether the odour of hydrocyanic acid was present.

Chronic Articular Rheumatism and Lumbago treated by Cold over the Spine.—B. O. Kinnear, M.D. (*Medical News*, August 20.)—The writer claims that he has treated with success a large number of cases of lumbago and chronic rheumatism by ice bags applied over the spine. The bags should never be wider than $4\frac{1}{2}$ inches. He says that in lumbago the dorsi-lumbar ice-bag (10 by $4\frac{1}{4}$ inches) will readily cut short an acute attack, and immediately comfort the patient.

The Specific Gravity of the Urine during Anæsthesia and after Salt Solution Enemata.—Thomas R. Brown, M.D. (*Johns Hopkins' Hospital Bulletin*, August, 1898.)—A number of experiments were made in the Gynecological operating-room to ascertain the effects of ether anæsthesia on the secretion of urine. The urine secreted during the anæsthesia was quite different from the ordinary. The colour varied from pale straw to that of water barely tinged, and the specific gravity had decreased from an average of 1017 to 1006. There was no hydruria, for the quantity of urine was not increased, and in a few cases it was decreased. The effect did not appear due to any nervous influence, for the decrease was as marked in those who took the ether with stoical calm as in very neurotic patients.

The second series of experiments were designed to determine the effect of enemata of normal saline solution on the specific gravity of the urine. Immediately after micturition the patient was given 500 cc. through a rectal tube passed as far as possible. The patient was not allowed to take any fluid during the next four hours. From 250

to 400 cc. of urine were voided in that period. The specific gravity fell from an average of 1016 to 1008, and the urine was very pale. There was evidently a true hydruria in these cases. The writer concludes that this rapid elimination of water suggests the value of enemata of normal saline solution as diuretics in renal disease. We may add that there is good evidence to show that water in large quantities, administered in any manner—by the mouth or rectum, intravenously or hypodermically—is superior to all other diuretics in suppression of urine. This fact is far from generally appreciated. See also an article on the treatment of puerperal convulsions in this Epitome.

Prolapse of the Mucous Membrane of the Vermiform Appendix into the Cæcum.

—H. D. Rolleston, M.D., F.R.C.P. (*Edinburgh Med. Jour.*, July). This condition differs from intussusception of the vermiform appendix into the cæcum, both anatomically and clinically.

A strong burly man, aged thirty-two, whilst travelling by train, was seized with violent abdominal pain. He was admitted to hospital on the following day, collapsed, and with a distended abdomen moving but slightly on respiration. The liver dulness was absent. He died in a short time. A diagnosis of perforative peritonitis was made. At the necropsy it was found that a duodenal ulcer had given way. The vermiform appendix was curled and fixed by adhesions below the cæcum. On opening the cæcum the prolapsed mucous membrane of the appendix was found projecting stiffly for about half an inch, and was considerably injected. The tip of the appendix contained a concretion.

The mechanism appears to have been this: The mucous membrane of the appendix had, from irritation of the concretion, projected and unfolded itself into the cæcum; the process was probably aided by contractions of the muscular wall of the appendix. An analogous condition is prolapse of the mucous membrane of the ureters from irritation of a stone.

Trophic Dermatoses following Fractures.

—Dr. Joseph Zeisler (*Jour. of Cutaneous and Genito-Urinary Dis.*) writes on this subject. His observations are new, for the only reference to the subject is a quotation in Malgaigne's "Traité des Fractures," 1847, from a certain Dr. Guenther, who noticed an arrest of growth of the nails of the right foot in case of fracture of the leg. Dr. Zeisler, having fractured his right thigh, made observations on himself. Even after six weeks the right toe-nails showed not the slightest growth. The dressing was then removed and he began to walk on crutches. But the nails grew very slowly. A deep ridge was noticed near the base, which slowly moved forwards, and the nail consisted of two por-

tions, a distal thin and atrophic and a proximal thick and strong. This atrophy is but part of the general atrophy of the limb, produced partly by the prolonged rest and bandaging, and partly through an influence exerted by the nervous system. The writer might very well have compared the furrows with those which are seen on the nails after severe illnesses. But, in the case of fractures also, the skin of the affected limb shows trophic and other changes. Dr. Guenther noticed, about eight months after the fracture, that small vesicles began to appear on the sole of the foot, which troubled him for some time. They were evidently connected with the fracture, for the whole limb was still reduced in volume. He observed similar vesicles in two other cases of fracture.

Apical Dulness without Pathological Changes.—Kernig (*Zeitschr f. Klin. Med.* Bd. 24 Heft. 3 and 4) has observed a well marked dulness at the apices of the lungs in about thirty-five extremely marasmic hospital patients, when post-mortem examinations revealed no pathological changes to account for it. When this is present the differential diagnosis from phthisis may be extremely difficult, especially as dulness with lessened breath-sounds is often the only physical sign of phthisis, and is met with in two classes of patients—(1) those who are well nourished and considered cured; (2) those who are extremely emaciated and dying of diarrhoea.

The following points assist differential diagnosis. (1) Dulness without morbid changes is always found in extremely marasmic hospital patients who are kept in bed. (2) The apical dulness of marasmus is always bilateral, and is accompanied by no other auscultatory signs, except diminished breath sounds. (3) The dulness may disappear. (4) Phthisical symptoms are absent. Kernig explains the phenomenon as follows:—Through the great muscular weakness and the concomitant rest in bed the average amount of air entering the lungs is lessened, to such an extent indeed that the apices are not properly filled with air, and from a diminution in volume and retraction sink lower than normal. It is possible that in some cases the dulness is produced partly by an atrophy, such as Seube described as senile atrophy of the lung.

The British Pharmacopœia, 1898.—The following excerpts from an admirable review in the July number of the *Inter-Colonial Med. Jour. of Australasia* should be of general interest to the profession:

"The alterations and improvements are so numerous as to emphasise decidedly the progressive character of pharmacy as well as of medicine, and the work has been done so thoroughly, and with such minute attention to detail, as to reflect the highest credit on the committee of revision. Not merely every page, but

every paragraph, and almost every sentence, has been subjected to most rigid criticism, and, if necessary, to alteration. It is scarcely an exaggeration to say that the new Pharmacopœia is practically an original work.

To proceed to mention a few points in detail, it may be summarily said that the changes consist of re-arrangements, alterations, additions, omissions, and miscellaneous changes of the nature of corrections, including in the last-named category, which is an extremely full one, changes necessitated by more accurate knowledge in chemistry and the other cognate sciences. The latter group includes chiefly such matters as corrected melting and boiling points, solubilities, and the like, which do not directly affect the medical man, although, in passing, it may be remarked that even among these there are some which will surprise. The solubility of carbolic acid, *e.g.*, which is dear to memory as "one in twenty," now appears as one in twelve, this change marking greater purity in the article, and a test demanding "absence of cresol" appearing concurrently.

Passing on to some points which are of more immediate interest to the prescriber, we find, in the first place, a lengthy list of about 180 articles which have been omitted. To begin with, all commercial and merely dietetic substances, which formerly encumbered the pages of the book, have been left out. All the vapours, poultices, and enemas, and soap suppositories disappear *en masse*. No less than nine decoctions and seventeen extracts, among the former being the all-embracing blunderbuss "decoctum sarsæ co.," and among the latter, such "tall poppies" as extracts of aconite and conium are omitted. Doubtless many physicians will regret the disinheritation of such familiar friends, but they may perhaps derive consolation from the retention of the compound gamboge pill, sulphurated antimony and Plummer's pill, ointment and plaster of iodide of lead, and confection of senna. The last-named viscous relic of primæval polypharmacy, to say nothing of the other antiques just mentioned, is perhaps retained out of respect for the domestic sentiments, or perhaps from a laudable desire to maintain the historic continuity of the new Pharmacopœia with its barbarous ancestor of 1618, in which various "fancy" articles, such as earth-worms, snails, woodlice, frogs, toads, &c., found official recognition. On the other hand, a few of the omissions are difficult to understand. For example, a large number of medical men, at least, think highly of dialysed iron, while many Edinburgh men in particular will regret the official demise of the compound tincture of chloroform, which was, so to say, a pet child of their venerable teacher, Sir Robert Christison.

The additions are much less numerous than the omissions, numbering only eighty-two, and most of

them are new *preparations*, but not new *substances*. Among the former are some new liquid extracts, of definite alkaloidal strength, a new group of concentrated solutions to take the place of certain decoctions, a new batch of probably useful lozenges, including eucalyptus lozenges, and others. Of new *substances*, one notes with satisfaction *bismuth salicylate*, *liquor pancreatis*, *liquor picis carbonis*, *naphthol*, and two preparations of the thyroid gland—a *liquor thyroidei*, and a *thyroideum siccum*.

The alterations will touch the prescriber somewhat more nearly, inasmuch as they affect the actual strength of many commonly used preparations, and the doses of more. To begin with, the fact may be noted that the metric system of weights and measures receives a more extended application than in the old Pharmacopœia, in which it was used only in the Appendix. In describing the modes of preparation of the various articles, equivalent proportions (not identical quantities), of the several ingredients are given in metric units, along with the quantities in imperial units, and the alkaloidal strengths of some extracts, &c., are stated in the same duplicate fashion. At the same time, strange to say, no attempt has been made to influence prescribers towards the permissive adoption of the metric system, as might have been done by giving metric equivalents for the doses. The strength of many preparations has been altered, as already said, and we recommend our readers to turn their especial attention to these changes, inasmuch as they affect a large number of frequently used drugs. The changes are, for the most part, beneficial. To begin with, an enormous advance has been made towards uniformity of dose in the preparations belonging to similar groups. The tinctures, instead of being given in all sorts of doses, now fall into two groups—the weaker group, whose invariable dose is from half a drachm to one drachm, and the more potent group, whose dose now is from five to fifteen minims. This same process has been applied to the extracts, the majority of which are now to be given in a “dose of either from a quarter of a grain to one grain, or from two grains to eight grains.” These changes necessarily imply corresponding changes in strength, and in some cases these are in the direction of increase; hence the importance of studying them carefully. Another amendment in the matter of dosage is the statement, in the case of certain articles which may be given either in a single dose or for repeated administration, of alternative doses appropriate to each of these two modes of employment.

The appendices have been greatly expanded, much encumbering matter in the text of the nature of tests of a general kind having been relegated to them. The main new feature, however,

is the introduction of a most excellent index, which is at once a list of drugs and their preparations, of the strengths of the latter, and of their doses, arranged in four parallel columns. This will be found of very great service to dispensers as an authoritative, complete, and convenient reference for dosage.

Oxygen in Morphine Poisoning.—David Playfair, M.D., C.M. (*The Lancet*, Aug. 27) A healthy woman, aged thirty-seven, took about 30 grains of acetate of morphia. Toxic symptoms were well marked. The stomach was washed out and atropine and strychnine were injected hypodermically. Respiration stopped and was continued artificially. Cyanosis became intense and the pulse exceedingly feeble. The inhalation of oxygen was commenced, the cyanosis became much less marked, and the pulse stronger. After about five and a-half hours of artificial respiration, the condition seemed hopeless: the pulse was getting weaker and the cyanosis became intense whenever the oxygen was stopped. Some improvement, however, set in, and she recovered. Among the remedies tried were ammonia and nitrate of amyl, but they seemed as useless as the others. Nothing was apparently of any value but oxygen. In other cases published in the *Lancet*, it has been found valuable: in one 2 oz. of chlorodyne had been taken (containing about 8 grains of morphine).

“Eudermol and its Use in Scabies.”—Wolters (*Therapeutische Monatshefte*, Aug. 1898, p. 443). Eudermol (nicotine salicylate) is a colourless crystalline substance, slightly soluble in water and organic liquids. It was used by Doutrelepon as a 1 per cent. ointment in scabies combined with baths of nicotine soap. In most cases no evil results occur; in rare instances nicotine poisoning has followed their application. One application of the ointment is generally sufficient, but it is better to repeat it three or four times for greater security. The dermatitis accompanying scabies also yields to this remedy, but in one instance out of sixty-seven an acute inflammation of the skin resulted from the application of eudermol.”

“Protective Inoculation against Cholera and Typhoid with Preserved Material.”—Pferiffe and Marx (*Deutsch Med. Woch.*, No. 13, p. 489). The method of Pfeiffer and Kolle of inoculating against typhoid, by means of an agar culture of bacilli (2 mg. of which, after eighteen hours' growth, are sterilised and injected subcutaneously), requires fresh material, whereas in time of war or epidemic it is important to be able to preserve the immunising material, and so to accumulate a store of it. Pfeiffer and Marx find that this may be done, in the case of the

immunising material of both these diseases, by the addition of 0.5 per cent. of phenol, by which means it may be preserved for at least 4-10 weeks. Further, a temperature of 37 deg. C. has no ill effect on the activity of their substances. The preserved typhoid antidote was used on three laboratory servants, and caused the usual reaction, fever, headache, and general feeling of illness. The symptoms lasted in one case one day only, in the other two as long as forty-eight hours. A subsequent testing of their blood showed as good result in antitoxic power as is obtained after inoculation with fresh material.

Congenital Diaphragmatic Hernia.—

A. J. Wood, M.D. (*Intercolonial Med. Jour. of Aust. February 20.*)—A boy aged fourteen months was admitted to hospital with a history of cold and cough for three days. He was a lively, well-developed, fair-haired child. The pulse was 114, and the respirations 48. The apex beat was in the fourth space in the right nipple line. The left chest, in the supine position, was dull, and the respiratory murmur was absent. Posteriorly intestinal gurgling was heard several times. On inverting the child the lower part of the chest became tympanitic. On another occasion the left chest, anteriorly, was tympanitic in the supine position, and dull in the sitting.

The child remained in good health, but the respiration was always rapid (about 50). However, seventeen months later some symptoms of intestinal obstruction—vomiting and constipation—occurred, and laparotomy was performed.

The stomach occupied nearly the entire abdomen. An aperture was found at the back of the diaphragm on the left side through which the descending colon passed. This was drawn upon, and gradually the whole of the intestines were pulled out of the chest, but no obstruction was found. He died before the operation was completed. The weather was very hot, and the cause of death was probably acute milk infection.

The case is unusual in the absence of attacks of dyspnoea. The dulness in certain positions in a chest filled with intestines is difficult to explain.

EAST LONDON HOSPITAL FOR CHILDREN.

Laryngeal Stridor Cured by the Removal of Adenoid Vegetations.—Dr. J. Shardlow (*Lancet*, Aug. 27, p. 552) reports a case under the care of Dr. Eustace Smith. The *Lancet* remarks that there are probably several causes of laryngeal stridor in children, and that the following case especially, when considered in connection with others recorded by Dr. Eustace Smith, shows that the presence of post-nasal "adenoids" is a factor in its

etiology. A rickety boy, aged eight months, was admitted with a history of having made a "crowing" noise and of dysphagia from birth. A distinct stridor was heard when the patient was lying quietly in bed, but when attempts at swallowing or crying were made he became extremely cyanosed, and during expiration not a sound was heard, but in inspiration a very loud crowing occurred. The mouth was constantly open, and there were well-marked depressions above the alæ nasi. Numerous adenoids were felt in the naso pharynx. In the chest there was well-marked inframammary recession and depression at the xiphisternum. The adenoids were removed. On the following day, there was no stridor, but when taking food he got attacks of dyspnoea and crowed during inspiration. These symptoms gradually passed away in three weeks.

Bleeding from the Upper Air Passages in Cirrhosis of the Liver.—

Dreyfuss (*Münchener Med. Woch.*, No. 32, 1,022). Little seems to be said in text books of medicine with regard to bleeding in cirrhosis of the liver, other than those forms which are directly due to increased pressure in the portal system. The occurrence of epistaxis is indeed generally recognised, but little is said as to its cause. Dr. Dreyfuss examined with the laryngoscope and nasal speculum two cases in which bleeding from the upper air passages occurred, and found that many small bleeding points were discoverable on the nasal mucus membrane, while the larynx in both cases was diseased. In the former case there was a small tumour between the vocal cords, on which a bleeding vessel could be seen. In the latter case, tubercular ulceration of the larynx co-existed with the liver disease. The causes of bleeding in cirrhosis of the liver besides the above-mentioned pressure in the portal system and its relief by collateral circulation, are an alteration of the vessel walls, and even perhaps of the blood itself, due to the poisoning of the general system by products of defective metabolism.

The Relation between Figure and Position of the Kidneys.—

Bechar and Lennhoff (*Deutsche Med. Wochenschr.*, No. 32, 1898) state that the idea held fifteen years ago, that almost all kidneys which could be felt during life were "floating" kidneys, quite apart from their position and mobility, has been abandoned. However, there is still confusion on the subject. Besides the true floating kidney there are others which, without being misplaced—the normal position of a kidney being very variable—can be felt bimanually, and move up and down with the diaphragm. The authors have tried to find out the reason of the kidney being sometimes palpable and sometimes not, by examining 324 persons. They conclude as follows:—(1) The presence of palpable kidneys

moving with respiration has nothing to do with tight lacing, as they occur in Samoan women. (2) Whether under physiological conditions a kidney can be felt or not depends entirely on the general build of the subject. The probability of the kidney being felt is greater the greater the distance between the sternal notch and the pubes, and the less the circumference of the abdomen, and *vice versa*. With practice inspection alone warrants a very good guess as to the possibility of palpating the kidney.

A New Occupation Disease.—Stern (*Münchener Med. Woch.*, No. 53, p. 1059). Under the name of "A Vesicular Exanthem observed in Tailor-esses and Sempstresses," Dr. Stern describes an eruption observed in five cases, the patients in each case being women employed in these trades. The eruption consisted of small vesicles the size of a pin's head, on a red base, closely set together; it started in all cases on the hands and forearms, and spread to other parts of the body, such as the calves, axillæ, groins, and chest. The blisters dried up without giving rise to any such moisture as accompanies a vesicular eczema, and no sign of "burrows" could anywhere be found, nor was any personal infection recognised, so that scabies was excluded. The eruption was accompanied by great itching, and remained very obstinate in all the cases while they continued at work. In one case an early cessation of occupation seemed to produce a very favourable effect. The most efficient remedy appeared to be Unna's carbol-sublimate ointment, consisting of carbolic acid two parts, and perchloride of mercury one part, with fifty parts of zinc ointment.

Cold Sponging versus Cold Bath.—Dr. H. A. Hare (*Therapeutic Gazette*, March 15) affirms that he has used cold sponging in his hospital practice and rarely the bath, with the most satisfactory results. He suggests the following rules of treatment:—1. In early typhoid, with constipation or moderate diarrhoea, give a full dose of calomel in divided doses, in order to stimulate the liver and antisepticise the bowel with bile. 2. Control the fever, when it reaches 102 deg. F., by sponging. The patient being stripped and laid on a rubber sheet, or blanket over a sheet, he is to be sponged with water adapted in its temperature to his needs, and it is to be remembered that the rapid application of a low temperature is more refreshing than the prolonged application of a higher temperature (Baruch). The chief advantage of the cold sponge lies in the shock and reaction. This is better obtained by the use of ice sponging than by the bath. The patient's surface is always bright red in ice sponging, often blue in the bath, and that the fever is not the chief danger in the case renders the fact that as great a reduction from the sponge is

not reached as from the bath of little importance except in hyperpyrexia. Shattuck tells us that he has found no marked or constant difference in the antipyretic value of cold sponging at 60 deg. F. for twenty minutes, the cold pack at 60 deg. F. for sixty minutes, or the cold bath at 70 deg. F. for ten or fifteen minutes. Finally, if this does not bring the temperature down to 100.5 deg. or 101 deg. F. in twenty minutes, resort should be had to the tub.

It is essential when the sponging is used that more water be applied to the back than to the trunk of the body, for at the back the great muscles and thick skin retain the heat as a reservoir, and are not cooled if only the front of the body is sponged. Further, the posterior surfaces are the ones apt to be congested and sore, from the dorsal decubitus, and therefore need the stimulating effect of the bath, as do the kidneys and other deeply situated organs. That this treatment is of value is shown by the marked redness of the skin, the improvement of the circulation and respiration, and the cleared mind. 3. It is advisable not only to use friction in a light form, but to use moderately active massage, with the same objects in view as when the rest cure is undertaken, for the proper treatment of typhoid is a modified rest cure. The writer is firmly convinced that by this means bedsores, local congestions and effusions, œdematous swellings, peripheral nerve pains, and muscular feebleness will be largely decreased, and Pospischal has shown that mechanical irritation of the skin is capable of increasing heat loss 95 per cent. 4. In nearly all cases give more nourishment than the average typhoid patient in the past has usually had. With the exception of broths and meats, almost any article easy of digestion should be allowed—as one or two or more lightly boiled eggs, corn-starch, arrowroot, &c. 5. Use stimulants in carefully graduated doses whenever the circulation needs them, particularly alcohol. Even the cold-bath enthusiasts give whisky to overcome the depression they often produce.—*Internat. Med. Magazine*.

Intestinal Tuberculosis.—Dr. N. Senn (*Am. Jour. Med. Sciences*, June 4, 1898) publishes an important paper on the subject of intestinal tuberculosis, which, he says, is seldom primary. It pursues a more benign and chronic course in adults than in children. The lower ileum and cæcum are most frequently affected. A number of cases of hernial tuberculosis have been reported, occasionally primary, but generally associated with peritonitis. Intestinal tuberculosis may run its course without any symptoms pointing to the alimentary canal. Thus an isolated lesion may cause no symptoms until perforation occurs. Baumgarten relates a remarkable case. A young soldier in almost perfect health died suddenly from perforative peritonitis. The necropsy revealed a

tuberculous ulcer the size of a penny in the lower ileum, and no signs of tuberculosis in any other organ. Clinically the case is exactly parallel to perforation in ambulatory typhoid fever. In other cases the symptoms are misleading; thus one case assumed the features of pernicious anæmia. In primary intestinal tuberculosis the symptoms are insidious, and are usually mistaken for intestinal catarrh, but traces of blood in the stools should arouse suspicion. The healing of an ulcer may cause stricture and intestinal obstruction. Chronic abscess in the abdominal wall in connection with long-standing intestinal symptoms suggests the probable existence of tuberculous intestinal ulcer.—*Lancet*.

Croupous Staphylococcic Tonsilitis: Fatal Perforation of Internal Carotid Artery.—Drs. A. Jacobi and James Ewing, of New York, report (*Philadelphia Med. Jour.*, 1898, No. 23) this case.

A child had the ordinary symptoms of croupous tonsilitis, with membranes on both tonsils. There were no Klebs-Loeffler bacilli. In a week the throat was pronounced clear, and the child much better. Then came on a severe chill, with rise of temperature, pain in the throat, dysphagia, and swelling of the lymphatic glands on both sides of the neck. Two days later there was considerable hemorrhage from the nares and pharynx, and two days afterwards a second very profuse hemorrhage, "filling a bowl" with apparently arterial blood. Two days later there was a third hemorrhage. The nares were then plugged. Two days later the plugs were removed, and a fourth severe and fatal hemorrhage occurred from the nares and the mouth. The necropsy showed that the fatal hemorrhage was from a perforation of the right internal carotid artery and the pharyngeal wall, while the condition of the internal jugular vein indicated that it or its branches were possibly the origin of the first hæmorrhage.

The account of this case is followed by references to some similar cases of pharyngeal hemorrhage.—*American Jour. of Med. Sciences*.

Fatal Dyspnœa from Hypertrophied Thymus Gland.—I. Under the title of "A Case of Spasmodic Dyspnœa," Dr. J. S. Barnett reports (*Lancet*, 1898, No. 3896) a case of laboured breathing, with suprasternal and subcostal recession, movement of the larynx and nares during respiration, which developed in a male child soon after birth. Tracheotomy was performed, and the child improved for several weeks, when he died during a prolonged attack of dyspnœa. The necropsy showed the trachea and larynx normal, and the thymus gland enlarged, the outlying lobules of the latter extending well into the root of the neck. This may have caused pressure

upon the recurrent laryngeal nerves, giving rise to spasm of the larynx, which was relieved by tracheotomy, the fatal termination being caused by further enlargement of the gland.

II. In the *Münchener Med. Wochenschrift*, No. 11, Dr. O. Clessin reports a sudden death due to a large thymus gland. A healthy child, two months old, was found dead in bed one morning, though it had seemed well at ten o'clock the evening before, and had never suffered from cough or dyspnœa. On post-mortem examination the lungs were found congested and showed petechial hæmorrhages, with signs of slight bronchitis. There were petechiæ in the heart muscle also. All the other organs were normal, except the thymus gland, which was so much enlarged as to overlie about two-thirds of the heart, while it furthermore compressed the trachea to such an extent that a pin could scarcely be passed into the tube. The thymus was dark, full of hemorrhages, and contained a large amount of dark secretion. The sudden death was attributed to acute swelling of the thymus, but the manner in which this arose was not clear. Friedleben was unable to cause such death by killing pups by strangulation, and Clessin has failed in attempts to produce it by tying the thymus veins.—*Amer. Jour. of Med. Sciences*.

Fatal Secondary Hemorrhage after Removal of Adenoid Vegetations.—Dr. Wallace Preble reports (*Boston Medical and Surgical Journal*, May 19, 1898; *Philadelphia Medical Journal*, 1898, No. 22) a case of fatal secondary hemorrhage on the eighth day after operation.

Urticaria of the Pharynx and of the Larynx.—I. In the *Philadelphia Medical Journal*, 1898, Vol. i. No. 14, Dr. John Madison Taylor, of Philadelphia, reports a "Case of Urticaria of the Pharynx, Producing Grave Œdema of Glottis." A lady, on attempting to sing shortly after dining, found herself unable to do so. A forcible attempt to sing produced a sense of discomfort confined chiefly to the throat, and this finally grew so great as to produce exhaustion, apparently due to impending suffocation. When seen shortly afterwards, the face was livid and cyanotic, the head thrown back, with gasping respiration and fluttering pulse, but without any mental disturbance. In some ten minutes or so urticaria appeared upon the skin and spread rapidly over almost the entire body, continuing for several hours, slowly subsiding in the next few days, and then occasionally recurring. The distress in respiration gradually diminished with the subsidence of the urticaria, and in a few days the patient was fully restored. The patient had been subject to attacks of severe urticaria twice before,

but without complication on the part of the larynx.

II. Dr. Frank Woodbury recently read a paper (*Philadelphia Medical Journal*, 1898, vol. i. No. 20) on "Urticaria of the Larynx Causing Asphyxia in an Adult." A merchant, subject to transient tumefaction of the face, had an attack after a mid-day lunch of bread, cheese, mustard, and beer and whisky. In a short time he gasped, turned black in the face, and fell on the floor, where he remained for a few minutes apparently dead. Respiration was restored artificially, and it was found that urticarial lesions were present upon the thigh and back. The patient seemed perfectly well again after a couple of hours' rest in bed.—*Amer. Jour. of Med. Sciences*.

Hemorrhage through the Ear from the Internal Carotid Artery after Tonsillitis.

—Walter H. Brown reports (*Lancet*, No. 3901), an instance of profuse hemorrhage from the right ear in a child aged five recovering from an attack of follicular tonsillitis, the source of hemorrhage eluding examination. The meatus was packed with iodoform gauze, and four days later another hemorrhage, more copious than the first one, took place four hours after the removal of the packing. Under the belief that the hemorrhage was due to an erosion of the walls of the internal carotid artery, in probable sequence to some inflammatory change surrounding the vessel, the common carotid artery was ligatured. Recovery followed.—*Amer. Jour. of Med. Sciences*.

The Treatment of Tic Douloureux by Strychnine (*Medical Record*).

—Dr. D. L. Dana reports a method of treatment which has been successful in many cases. The patients are put to bed and given a milk diet, and a daily injection of strychnine, beginning with one-thirtieth of a grain and increasing gradually to one-fifth of a grain. In some cases one-third of a grain was given. The treatment was continued about six weeks, during the latter part of the period the dose of the strychnine being gradually reduced. In two cases the first course of treatment had to be supplemented by a second one of three weeks' duration. In one instance the patient was under treatment three months. One of the four patients had not only a most severe form of tic, but also the morphine habit, which increased the pains. There had lately been some exploitation of the opium cure of tic douloureux, but in spite of the fact that it had been recommended by such men as Charcot and Ferrier, he thought it was unfortunate for the general practitioner to get the idea that opium was good in this disease. He had seen some very disastrous results from its use. His reason for again mentioning the treatment which he had practised for three years, was that there seemed to

be great misapprehension as to its nature by many. Some had said they had given strychnine a few days, or a week or two, but it had done no good, and they had pronounced the method a failure. There was no use in commencing the treatment unless it was carried to the full extent, for very often the symptoms were even aggravated the first two or three weeks.

In reply to interrogatories, Dr. Dana said the injections of strychnine were not made over the seat of pain, but anywhere convenient. He had not tried administering it by mouth, but thought there might be some danger of an accumulated dose from temporary retention in the tract. One of the ten patients had been a sufferer for thirty years, and had been operated upon by nearly every surgeon in New York; the face was badly scarred in consequence, but the pain had not been permanently relieved until this medicinal treatment was given. It was important to keep the patient in bed during the treatment.—*Indian Lancet*.

Pneumococci in the Throats of Healthy Persons.

—At a meeting of the Société des Hôpitaux of Paris (*Philadelphia Medical Journal*, 1898, No. 21) Bezancon and Griffon reported the result in their studies relative to the presence of pneumococci in the throats of healthy persons, having employed the serum of a young rabbit as a culture medium. They examined, bacteriologically, the secretion from the tonsils of forty persons of all ages, living under the most diverse conditions, and found pneumococci in every individual. They believe that imperfect methods of investigation must have been pursued in previous observations in which pneumococci were found in a much lower proportion of healthy throats.—*Amer. Jour. of Med. Sciences*.

Early Spinal Syphilis: Brown-Séquard's Paralysis.

—A man aged forty, one year after contracting syphilis, noticed diminution of his sexual power. Ten days later he became lame in the left leg. When seen three weeks after the onset he walked with difficulty supported by a cane; his gait was spastic and hemiplegic on the right side. The flexors of the right thigh, leg, and the dorsal flexors of the foot were markedly weak; the extensors of the thigh, lower leg, and plantar flexors of the foot were nearly normal. On the left side below the level of the umbilicus, the sensation of touch was accurately located, but he could not distinguish the head from the point of a pin, nor heat from cold, nor feel pain. The deep reflexes on the right side were exaggerated; there was patellar and ankle-clonus. On the other hand, the superficial reflexes were more active on the anæsthetic side. There was therefore crossed paralysis of the form described by Brown Séquard.

But it was of the incomplete form, which is not very uncommon in spinal syphilis. The complete (in which there is total loss of sensation on one side and motion on the other) is produced by hemi-section of the cord, but is rarely present in spinal syphilis. It is only found where there are isolated unilateral gummata accompanied by meningitis.

Mercury and iodide of potassium were given in increasing doses. In a month there was marked improvement. He regained his power of walking, but some weakness, the exaggerated reflexes and the impotency remained.

The writer refers to the mistaken general opinion that affections of the nervous system do not occur early in syphilis. He discusses the question why, in this case, the muscles described by Mann as the "shorteners" of the leg, should be paralysed, and those described as the "lengtheners" should not be paralysed. He is driven to the explanation that the latter, having to deal with standing—a double-sided function ordinarily—have a double-sided innervation.—*New York Med. Jour.*

Hæmophilia Treated with Chloride of Calcium.

—Dr. A. E. Wright suggested the possibility of increasing the power of coagulation by means of this drug. He made some valuable researches, and showed that the administration of chloride of calcium did cause an increase, the time in hæmophilia being reduced one-half. The following case reported by Dr. Clifford Perry is noticed in the *Revue des Sciences Médicales*. Severe hæmorrhage followed incision of a dental abscess in a case of hæmophilia. Only after four hours' energetic work, and packing the whole space between the alveolar process and the cheek with gauze saturated with strong solution of perchloride of iron did the hæmorrhage cease. Later epistaxis and recurrence of hæmorrhage from the wound took place, which ceased only when the patient was on the verge of collapse. After six hours alarming hæmorrhage again occurred which all ordinary means failed to stop. Chloride of calcium was given in doses of two grains every four hours. In a few hours the effect was marked; a firm clot formed and the hæmorrhage ceased.—*Lancet*.

The Treatment of Gastric Hyperacidity.

—Dr. Elliott P. Joslin (*Boston Med. and Surg. Jour.*, 1898, No. 17, p. 389) states that if the motility is at fault the general condition is to be benefitted, and rowing and golf, by strengthening the abdominal muscles, will give support to the overloaded organ. Massage by a skilful operator may empty the stomach, and so be of value. Electricity is of no use. Only one drug is of value, and that only when given in a particular way; ten drops of the tincture of nux vomica thrice daily,

increasing one drop daily until a maximum daily amount of sixty to ninety drops is reached. Should these measures not suffice, the stomach-tube should be employed. This, however, is exhausting, and besides a large amount of food is in this way removed from the body. In one instance the estimation of the nitrogen in the stomach washings revealed the fact that nearly one-fourth of all the food given by the mouth was removed by the tube on the following morning. As the stomach absorbs no water, it is in these severe instances of hyperacidity associated with gastric dilatation that thirst is troublesome. This is best relieved by nutrient enemata of normal salt solution. Food is also absorbed extraordinarily well by the rectum, and in one instance 87 per cent. was so taken up. Rationally, an albuminous diet is wrong in hyperacidity, but all acknowledge the temporarily good effects of proteids, and in the milder cases the symptomatic treatment seems indicated rather than the rational: carbo-hydrates for the severe, and proteids for the mild form. Yet the author has almost invariable satisfaction with the proteid diet. On giving carbo-hydrates, since the ptyalin is soon destroyed in the stomach, foods in which the starch has been converted into dextrin are indicated or diastase administered. The pain arising from the acid itself may be neutralised in various ways, the simplest of which is to dilute the acid with liquid. This, of course, should not be encouraged, for fear of producing trouble with motility, and thereby augmenting the existing condition. Another means is to give a diet which will combine with the excess; this is the albuminous. That this is powerful in its action, is shown by the fact that two or three eggs will combine with a pint of 0.2 per cent. hydrochloric acid. Further, the products of proteid digestion—that is, peptones—have the power of combining with a greater quantity of hydrochloric acid than the original proteids. This fact suggests that it would be more rational to administer peptones. The aim should be to give food in small bulk, and such preparations as malted milk tablets may be of service. If held in the mouth for some time, they may be useful in increasing the alkaline saliva; thus, the organism furnishes its own alkali. As for the alkalies proper, all agree that they are temporarily of great use, though in time they lose some of their power, and are purely symptomatic. Combined with bismuth, their action is promoted. The special variety is not of importance, but large doses must be given. No matter what the treatment, or rule, of diet is in any case of stomach trouble, it should be always borne in mind that the marasmus of probably all stomach patients, excepting those with cancer, arises from the diminished amount of food eaten. Patients can get along without a stomach, but not without food.—*American Jour. of Med. Sciences*.

Pure Lymph (*Therapist and Treatment*, May 12, 1898).—E. F. Willoughby, M.D. Lond. Accustomed as we are to "arm-to-arm" vaccination, and the demand for lymph "direct from the calf," it will be a surprise to most persons to learn that no lymph is sent out from the Government vaccine institutes in Germany until it has been kept four months. It is true that ordinary lymph, when stored in tubes, rapidly deteriorates, but this is owing to the growth of extraneous microbes crowding out the specific micrococci. It is they, and not, as has been supposed, coagulation of the fibrin or albumen in the lymph that cause the opacity in the contents of tubes after a few weeks; but it has been proved that the addition to the lymph of an equal volume of a 50 per cent. solution of glycerine in distilled water exerts an inhibitory influence on the extraneous, but not of the specific, microbes, which are thus left free to multiply. Such prepared lymph is soon converted into a pure culture, which gains instead of losing, in activity by keeping—at any rate, for periods under a year—if under suitable conditions of temperature and light. The extinction of the useless microbes, of those which deteriorate the energy of the lymph or give rise to inflammations, is effected in about three to four months; and it is not till then that the lymph is issued for use, samples containing more than an average of one bacillus or torula of any kind in the cubic centimetre being rejected. A large proportion is absolutely free.—*Glasgow Med. Jour.*

A Case of Intestinal Obstruction due to Lumbricoid Worms, simulating Appendicitis: Operation, Recovery.—E. H. Bartley, M.D. (*Archives of Pediatrics*, April, 1898). A girl aged six years (subject to attacks of acute gastric catarrh), was seized—following indulgence in indigestible food—with a severe and persistent attack, with pain, vomiting, &c., ejecting a worm with the vomit. Four days after the beginning of the attack an operation was performed and a ball of entwined lumbricoids were found in the ileum, resting against the ileo-cecal valve, completely occluding the opening. About forty worms were removed.—*Internat. Med. Mag.*

Changes in the Larynx and in the Trachea in Leucæmia.—The *Philadelphia Medical Journal*, 1898, No. 23, summarises from the *Münchener Medizinische Wochenschrift*, April 19, a report by Otto Barnick, of a case of a boy, aged thirteen who was the subject of leucæmia. He had attacks of severe dyspnoea, with croupy cough. Laryngoscopic inspection revealed great thickening of the ventricular bands, and infiltration of the whole upper portion of the larynx. The child died with severe dyspnoea, aphonia, and bleeding from the mouth and nose. On post-mortem examination it was found that the infiltra-

tion of the larynx and bands was due to a dense collection of lymphocytes in the submucous tissue. The capillaries, also, were distended with lymphocytes, and these cells were especially abundant in the interglandular spaces. The submucous tissue in the trachea was affected in the same way.

Dr. Otto Barnick, clinical assistant in Prof. Habermann's Clinic at Gratz, contributes an elaborate article to the *Münch. Med. Woch.*, 1898, No. 19. He reports three new cases in the clinical services of Professors Escherich and Kraus. The lesions, as pointed out by Virchow, are lymphoid nodules, simulating tubercles, in different portions of the respiratory mucous membrane, with infiltration, sometimes so great as to require tracheotomy, which, often merely postpones the fatal termination.—*Amer. Jour. of Med. Sciences.*

Intubation of the Larynx to Control Vomiting.—At the recent meeting of the British Medical Association (*British Med. Jour.*, October 16, 1897) Dr. Charles Lyman Greene, of St. Paul, Minn., read a paper upon "The Feasibility of Controlling Pernicious Vomiting by means of Intubation of the Larynx with a Specially Adapted Tube." The tube is, in general, like the O'Dwyer tube, but differs in certain particulars. The project is seemingly supported by experiments upon the lower animals, and apparently confirmed by a case recently under Dr. Schadle's treatment for chronic laryngeal stenosis by forcible dilatation. This patient was wearing a tracheotomy tube, and, during the passage of the large oesophageal bougie employed, the man makes the most violent efforts to vomit, but cannot expel any of the contents of the stomach, whether that organ be full of food or not.—*American Jour. of Med. Sciences.*

Foreign Bodies in the Bronchi.—An exceedingly instructive case is narrated by Dr. Alfred Austin Lendon, of Australia (*Inter-colonial Medical Journal of Australasia*, 1898, No. 3).

A boy, seven years of age, while taking a bath, January 28, 1888, accidentally inhaled an ebonised stud, and for three days felt pain in the chest at a spot corresponding with the second right costosternal articulation. Despite this history, he was treated for more than a year for asthma, the story of the foreign body being discredited. In January, 1889, he had an attack of acute pneumonia of the right lung, commencing with a moderate hæmoptysis, and on the subsidence of the attack his expectoration became purulent, very offensive, and more profuse than before.

On March 2, 1889, he was admitted to hospital with great dyspnoea, frequent short hollow cough, and profuse fetid purulent expectoration, amounting to a half-pint in the twenty-four hours. Exploratory punctures

with the aspiratory needle securing pus, an inch or more of the fourth rib at the right upper axillary region was excised, and the pleural cavity opened, but there was no pus; the lung itself was then punctured, and still no pus could be reached. Some slight recent adhesions between the upper and middle lobes were then broken down with the finger, and this liberated a small quantity of pus. The finger reached the pericardial sac in the nipple-line, and the lung was felt to be retracted from the clavicle. While manipulating, Dr. Lendon felt what he believed to be the stud, with some lung tissue intervening between it and the finger, but subsequent digital exploration failed to detect it again. A drainage-tube was inserted and the wound sewed up. No sooner had the doctor left the hospital than the boy expectorated the stud in a violent paroxysm of coughing, during which he said he felt it in its old place in his chest. For a few days he had great dyspnoea and rapid pulse, but soon recovered.—*Amer. Jour. of Med. Sciences.*

Hæmorrhagic Effusions into the Pleuræ and Peritoneum in the course of Hepatic Cirrhosis.

Barjon and Henry (*Lyon Medical*, June 19, 1898) have collected four cases, three of which were confirmed by an autopsy; in all four there were hæmorrhagic pleural effusions on the right side, and in two of them, in addition, there was ascitis—at first serous, but subsequently hæmorrhagic. From a critical examination of these and other recorded cases, especially those collected in Jean's thesis (Paris, 1891), it appears that cirrhosis tends to set up right pleural effusion, and that this effusion is much more often hæmorrhagic than the ascitic effusion. The hæmorrhagic nature of the effusion is generally due to concomitant tuberculosis; in some instances, however, especially in those of ascites, where the effusion was first clear and only subsequently hæmorrhagic, no evidence of tubercle is forthcoming; and it appears that traumatism exerted by the puncture gave rise to hæmorrhage from the dilated vessels forming the collateral circulation in the peritoneum.—*Practitioner.*

Treatment of Pertussis by Means of Asaprol

(*La Médecine Infantile*, January, 1898).—Moncorvo has found that corrosive sublimate, resorcin, citric acid, and benzo-naphthol are capable of promptly destroying the organism of pertussis. In cases of the disease he has applied a solution of resorcin by means of a brush with a long curved handle, to the posterior pharyngeal walls and about the region of the glottis, with excellent results. Latterly he has substituted asaprol—in the form of an aqueous solution of the strength of 1 to 100. This solution was applied every two hours in the day. In a series of twenty-six cases, ranging in age from one month to nine years,

when the remedy has been applied from the beginning of the attack, the case has been cured before the convulsive stage and when this stage has been reached, recovery followed in from five to ten days. The solution is of a sweetish taste, and consequently well borne by infants. In the beginning it induces attacks, but this is very shortly overcome.—M'C. Hamill, *International Med. Mag.*, April, 1898.

Note.—Asaprol. This name is given by MM. Dujardin-Beaumetz and Stackler to one of the derivatives of beta-naphthol—viz., the sulphuric ether of beta-naphthol, in the form of a salt of calcium containing traces of naphthol and calcium sulphate. Asaprol is a white powder extremely soluble in water and alcohol. Its antiseptic properties are nearly equivalent to those of sodium salicylate. It allays pain and reduces temperature, and is recommended for internal administration in acute rheumatism. It is rapidly eliminated by the kidneys, and is comparatively free from toxicity.—Shoemaker, *Materia Medica and Therapeutics*, third edition.

The difficulty of painting the throat of children suffering from whooping cough seems to have been greatly minimised. The use of the spray in this condition, at least for older children, seems preferable.—*Glasgow Med. Jour.*

Severe Cerebral Symptoms and Death from Excessive Dilatation of the Stomach.

—Von Jürgensen (*Deutsches Archiv. für Klin. Med.*, Bd. lx., p. 327) reports the case of a farmer, aged forty-three years, who for ten years had occasional attacks of pain, fulness, and sense of oppression in the epigastrium after meals. Anorexia and excessive appetite alternated; during the attacks vomiting was frequent. The patient was emaciated, pale, and sallow. The abdomen was distended, the superficial veins prominent. The stomach was much dilated. The patient refused mechanical treatment, and was treated by wet-packs, diet, rest in bed, and papain internally. The latter, he thought, lessened the tympanites, but the general condition became distinctly worse. He complained of great weakness and severe thirst. Water was vomited as fast as swallowed. The thirst was so great that in one night ten litres of water were drunk and vomited. The intellect became slightly clouded, there were ataxic movements of the arms and legs, later general spasms. The symptoms grew worse. The urine, scanty before, was suppressed. The thirst and vomiting persisted. He became comatose, irregular breathing, cyanosis, cold extremities, loss of reflexes, spasms, and vomiting continued until death. Necropsy showed the greater curvature of the stomach at the level of the umbilicus, the lesser curvature forming an acute angle, the sides almost touching. The greater curvature measured 55 cm., the height

from the fundus to the cardia 20 cm., and the depth 14 cm. One centimètre below the pylorus was a stricture of the duodenum, caused by a ring-shaped scar. The duodenum above this and the pyloric part of the stomach were dilated. The mucous membrane of the stomach was thin and smooth in the pyloric portion, unusually folded at the fundus, where there was slight *état mammelonné*. The muscular coat of the stomach was hypertrophic. The œsophagus was dilated and hypertrophic, the epithelium thickened in areas.

That the death was due to an intoxication of some kind was clear, and the author, showing that diabetes, cancer, and cholæmia were not present, in view of the enormous thirst and the failure of absorption, ascribes the fatal symptoms to lack of water in the blood and tissues, and intoxication from the suppression of urine. It will be remembered that Kussmaul, in his earliest work on dilatation of the stomach, looked on lack of water from lessened absorption as of great importance, but afterwards abandoned the idea.—*American Jour. of Med. Sciences*.

A Practical Ice Dish.—Dr. Lester Keller (*Medical Council*, June) thus describes a practical dish for keeping crushed ice :

Take an ordinary unglazed, porous flower-pot that will hold two quarts or more, a quarter of a square yard of white flannel, a strong string and a flat-bottomed dish.

Spread the flannel out over the top of the pot, then push the flannel down in the centre so as to make it funnel-shaped, but do not let the flannel go clear to the bottom of the pot. Tie the string around the flannel and pot near the top, set the pot in the dish.

Put the ice between two layers of stout cloth, lay it on a solid surface, and pound it with the side of your hatchet until it is well crushed. Put the crushed ice in the funnel of flannel and you will be delighted to find that you can dip up a spoonful of ice without water. You will be surprised to find that in the hottest weather the supply of ice has lasted all night. The ice dish makes a very convenient place to put a glass of milk to keep it cool, if need be.—*Internat. Med. Mag.*

Subcutaneous Injections of Saline Solution.—Jacobs (*La Gynécologie*) while admitting the great value of saline injections in cases of profuse hemorrhage, states that in so-called "delayed shock" the results have not been satisfactory; artificial serum has no bactericidal action, nor does it oppose any barrier to the entrance of infection.

SURGERY.

Operative Wounds of the Thoracic Duct.

—Harvey W. Cushing (*Ann. Surg.*, Philadelphia, June, 1898), of Baltimore, draws attention to the very scanty information on this subject in standard text-books. It is rare that the thoracic duct, or one of its large branches, should be injured during operations on the left side of the root of the neck. Under ordinary anatomical conditions the duct does not rise above the level of the junction of the two great veins, and, till recently, routine dissections have not carried the operator to this region of the supra-clavicular triangle. At the Johns Hopkins Hospital operations for carcinoma of the breast are almost invariably extended above the clavicle, where glandular enlargement, though not previously palpable, is found in a large number of cases; and during this dissection the angle between the veins is usually exposed. Among sixty cases so treated, thirty-five have been on the left side of the neck, and in only two has the duct, or one of its large branches, been injured. One of these was not recognised till the subsequent formation of a chylous sinus. There was never any similar injury in dissecting out tubercular glands. In the two cases referred to, one was remarkable from the fact that the wound in the duct was a visible one, and was successfully closed with a fine silk suture. Keen has the credit of recording the only previous case of successful suture of the duct. A summary is given of six other cases, in two of which the wound healed by first intention, but broke down on the tenth day, leading to a chylous fistula, which threatened starvation.

The duct, when occupying its normal anatomical position, is but little exposed to injury during operation. From the surgical standpoint, anomalies of the cervical part of the duct, which carry it high into the neck, are important.

In the treatment of wounds of the duct, suture is doubtless the ideal method, but must be confined to those fortunate cases in which the duct is fully exposed, and has not been completely divided. If suture is impossible, it is recommended to place a provisional ligature about the duct, on the proximal side of the wound, and to control the leakage, if possible, by plugging with gauze. Should, however, the leakage become uncontrollable, and threaten starvation, the provisional ligature should be tied, with the hope of a final readjustment of collateral circulation, or trusting in the presence of some anastomotic branch which might suffice to carry the lymph into the venous circulation.

The abstractor had the opportunity, some years ago, of observing a case in which the main duct was wounded in the course of a dissection for the removal of a sarcoma from the supra-clavicular triangle. Milky chyle spurted from the wounded

duct, and continued to leak, in spite of plugging of the wound, until the death of the patient six weeks later. Probably many similar disasters have occurred in surgical practice, and have not been published.—*Edinburgh Med. Jour.*

Strangulation of the Penis.—Dr. Theodor Floras reports (*Deutsche Med. Woch.* of July 14) a case of incarceration of the penis. The patient was a railway employé, about 55 years of age, who, presumably while in a state of intoxication, in the presence of a companion, passed his relaxed penis through the aperture of an iron-screw nut, this apperture having a width of only 1.5 centimètres (0.6 in.). The matter was treated as a joke, and encouraged by his companion, he forced the nut with a twisting movement until it arrived at the attachment of the ligamentum suspensorium urethræ. He was subsequently unable to remove the nut, but nevertheless went to work that same day, and also the next. On the evening of this second day he consulted a surgeon, who drew off his retained urine with a fine catheter, prescribed a diuretic, and directed lead lotion to be applied to the penis. Next morning that Dr. Floras saw him, more than thirty-six hours after the application of the nut. The penis hung down like an enormous, tightly-filled sausage, and the diffuse swelling was so great that it was difficult to find the nut among the infiltrated tissues. Amputation seemed to be unavoidable, but before resorting to it the man was taken to the engineering shop and held by two men in the upright position against a large anvil. The penis, with the square nut encircling it, was then held horizontally on the anvil, a slight cut was made in the nut by a sharp chisel, struck by a hammer, and this cut was cautiously deepened until an iron wedge could be driven into it, whereupon the nut broke in two. The internal screw threads of the nut had sunk into the tissues of the urethra, and had caused ulcerative and necrotic changes, but in a few days all the symptoms disappeared, and the man returned to his work. Dr. Floras refers to a somewhat similar case recorded by M. Ameisen, quoted in the *C. für Chirurgie* for 1897, p. 1, 166.—*Lancet*, July 23.

Surgical Treatment of Intestinal Tuberculosis.—Margarucci (*Il Policlinico*, Nos. 4, 6, 8, 10, 1898) states that the parts of the intestinal canal most frequently affected are, in their order of frequency, the last part of the ileum, the cæcum, and the first part of the ascending colon. Bacilli may reach the intestine in the food, or through the blood. If by the first way multiple ulcerating foci result, if by the second an exuberant production of inflammatory tissue about tuberculous granulations in a limited area of the intestine is formed. Women of middle age are most often affected. Pain may be diffused or localised,

continuous or spasmodic. Nausea and vomiting are frequent. Tumefaction, which easily changes in volume, in the painful part, may be detected. The painful spasm is followed by diarrhœa. These symptoms are more common where there is some stenosis, either from cicatrization of old ulcers or from tuberculous growths. The best treatment is resection of the affected parts. The author refers to seven cases which were operated upon. The mortality was 42.8 per cent., with four cures. Details as to the operative technique are given. Pantaleoni (*Arch. Prov. de Chirurgie*, June, 1898) reports a case of tuberculous stenosis of the small intestine in a woman aged thirty-three years, in which he removed, with complete success, about five inches of the affected gut, the walls of which were much thickened and of cartilaginous hardness. The divided segments of intestine were brought together by three rows of sutures. The operation was a long and complicated one, as it was found necessary, not only to remove a portion of the mesentery, but also, as firm adhesions had taken place between the affected loop of intestine and the posterior surface of the bladder, to resect at the seat of this adhesion the serous and muscular layer of the vesical wall. In this case there was no restriction in food. Some tea was swallowed about three hours after the operation, and after the first twenty-four hours the patient was allowed to take what she fancied. The author holds that if the two ends of the divided intestine be carefully and properly united by sutures, and if the operation prove to be an aseptic one, no risk should attend the passage of food already reduced by the digestive processes to a thin and absorbable pulp. The paper contains a careful study of the clinical character and diagnostic signs of intestinal tuberculosis, and a review of twelve previously recorded cases in which this morbid condition was treated by enterectomy.

Pneumaturia.—(*Jour. of the Amer. Med. Assoc.*, Aug. 20, 1898). Drs. H. A. Kelly and W. G. MacCallum contribute an exhaustive paper on this comparatively rare symptom. Pneumaturia may be due to (1) the mechanical introduction of air into the bladder from without during catheterism, cystoscopy, &c.; (2) microbic fermentation in the urinary tract, or (3) communication between the bladder and an air containing viscus, usually the intestine. In most cases of the second class the gas was produced in the bladder, but in a few in the kidney. Most of the cases occurred in middle-aged or old men, the subjects of urinary obstruction—prostatic enlargement or stricture. The essential factor was the introduction of organisms by instruments. In nine out of the sixteen recorded cases there was glycosuria; in two the organism was recognised. In one it was a yeast, in the other a

bacillus resembling the bacillus coli communis. In sugar-free urine the organisms all belong to the group of which the bacillus coli communis is a type, in one it was the bacillus lactis aërogenes, in another the bacillus aërogenes capsulatus. Alcoholic fermentation with formation of CO_2 , has been observed in the glycosuria cases. H forms the bulk of the gas in the other cases, but CO_2 , N, O, and CH_4 have been found. The passage of the gas causes a tickling sensation and soufflé. Recovery occurred in all the cases, and was accelerated by antiseptic lavage.

In the third class the communication may result from congenital fistula, traumatism, or necrosis of the tissue between the bladder and intestine. The diagnosis of this class is generally easy; passage of gas, together with faecal material, is pathognomonic. If doubtful, coloured injections into the bladder or rectum may prove the existence of a fistula, or the bladder may be inflated with air and examined with the cystoscope. The prognosis of the traumatic cases is the most favourable; the fistula often heals under rest only. Treatment may be palliative or curative (operative). The former consists in the giving of food which produces little faeces, washing the bladder and rectum, and keeping the patient in such a position that gas only passes into the bladder.

Foreign Body in the Nose for more than Forty Years.—The *Journal of the American Med. Assoc.*, 1898, No. 24, reproduces from the French Congress of Otology and Laryngology the case of a patient complaining of purulent rhinitis, in whom a canula was found in the left nasal passage, into which it had been inserted forty-two years before and forgotten. A radiograph showed that the upper end of the canula was still in the nose. It was extracted through the inferior meatus, when all disturbance ceased at once.—*American Jour. of Med. Sciences.*

Double Resection of the Inferior Maxilla for Protruding Lower Jaw.—J. W. Whipple, D.D.S. (*Dental Cosmos*, July, 1898), describes a successful double resection of the lower maxilla.

The operation was performed upon a man aged twenty-six, who had hypertrophy of the body of the maxilla, forming a short shaft between the first and second bicusps on the left side, and between the first molar and second bicuspid on the right; the space separating the teeth being respectively one-fourth and one-eighth of an inch, causing an elongation of the jaw horizontally, which projected the lower teeth about one-fourth of an inch beyond and in front of the upper. The growth having been greater on the left side the teeth were slightly deflected to the right. Occlusion was destroyed,

only the distal cusps of the second molars articulating; proper mastication was impossible, and vocal articulation greatly impaired. The chin was sharply projected.

An incision was made, about half-an-inch long, along the base of and just interior to the inferior border of the maxilla. A cross incision was made, of the same length, on a line with the mental foramen. The muscles and other soft parts were detached; Dr. Blair, the operator, with a double bone saw, made a clear cut on the left side, as wide as the space between the two bicusps. The sawing was accomplished through the incision, from and through the internal surface of the bone from the superior border down to the base. No vessels were ligatured, the hæmorrhage not being profuse. The bone was cut almost, but not quite through; no attention was given to the contents of the inferior dental canal.

A small hole was then drilled through the bone, on each side of the cut, near the inferior border, for the reception of a wire ligature. The right second bicuspid having been previously extracted, the operation was repeated on the other side. After the holes were drilled, the remainder of the sawing was done on both sides, and two small sections of the jaw removed. Soft copper-wire ligatures were passed through the holes from the external surface. These were crossed on the internal surface, grasped with a pair of pliers, and twisted until the parts were drawn together. At the end of the third week the means adopted for holding the severed maxilla in position had proved ineffective; the parts had failed to unite on either side. Molar and bicuspid bands, with knobs and traction bars, and a figure of eight wire ligature adjusted to the knobs, were then used, traction was applied, and the parts drawn close together. The patient lived on liquid food, and suffered no great inconvenience physically. A four-tailed plaster bandage was adjusted and retained without change for four weeks. The drainage wounds at the points of incision were dressed every other day, and kept open with drainage gauze. Borolyptol was used as a mouth wash.

At the end of eight weeks strong osseous union had been secured on both sides. Perfect occlusion of the teeth was attained by crowning. The left central and lateral incisors being properly overlapped by the upper teeth. Dr. Whipple states that the patient's appearance has greatly improved, and that no one would suspect that an operation had been performed.

In an article in the August number of the *Dental Cosmos*, E. H. Angle, D.D.S., of St. Louis, in commenting upon the operation, questions the advisability of wiring the ends of the bone together in the treatment of fractures of the maxilla. He maintains that it is a mistake to ignore the natural and suitable attachments which may be obtained

by means of the teeth for the fixation of the fractured bones, and points out that if Dr. Blair had used the teeth as a means of fixation in the first instance, instead of wiring, there would have been no difficulty in obtaining early union. He further says that the plan of making wounds, which must become septic, on each side of the wound to be treated, might have been excusable in the days of Buck and Kinlock, but that modern surgery demands better methods.

The two important points established by Dr. Blair's operations are:—(1) That union of the bone will take place; and (2) That the vitality of the teeth in the anterior section need not be impaired. This was probably the first operation of the kind ever performed, and as a means of correcting an unpleasant disfigurement should be of much interest to the surgeon.

Protargol in Conjunctivitis.—*Boston Med. and Surg. Jour.*, Aug. 25, 1898. Protargol is a silver-protein compound, introduced in 1897 by Neisser for the treatment of gonorrhœa. It is not precipitated by albumen, which permits of its penetrating the tissues more than other silver salts. Neisser states that he has never had such uniformly good and rapid results as from this substance. Dr. F. E. Cheney has used protargol in 130 cases at the Massachusetts Eye Infirmary, and finds that it possesses all the advantages, and none of the disadvantages of nitrate of silver. A ten per cent. solution causes less irritation than one per cent. nitrate of silver. In a number of cases of ophthalmia neonatorum he used protargol (two to four per cent.) to the right eye, and nitrate of silver (one to two per cent.) to the left. The lesser degree of irritation produced by the former was very noticeable, and its curative effect was equal. He also used protargol in catarrhal conjunctivitis, and chronic conjunctivitis (half per cent. solution), and in granular conjunctivitis (four per cent. and ten per cent. solutions), and the results were quite as satisfactory as from nitrate of silver.

A Case of Perforating Gastric Ulcer: Operation at End of 24 Hours: Recovery.

—Dr. A. T. Cabot (*Boston Med. and Surg. Jour.*, Aug. 11, p. 134) publishes the following case, which is unusual, in that recovery followed laparotomy at so long an interval after perforation. Usually operation, to be successful, must follow closely on the accident. A woman, aged 30 years, who had suffered from symptoms of indigestion, was suddenly seized with violent abdominal pain. She became collapsed, and the abdomen rapidly swelled. The abdomen was tensely distended, and was tender everywhere, but especially in the epigastric and left iliac regions. The liver dulness entirely disappeared. Laparotomy was performed

on the following day. The peritoneum was moderately injected, and contained a small amount of turbid serum, but no stomach contents were seen. On the lesser curvature of the stomach, a yellow sloughy area, covered with fibrin, and perforated by a minute opening, was found. The opening was closed by folding the stomach wall together over it with Lembert stitches in two rows. The patient made a steady and uninterrupted recovery.

Congenital Dislocation of the Hip-joint treated by the Lorenz Method.—Dr. Royal Whitman (*Medical News*, N.Y.) reports successful results. The operation depends on the fact that a well-marked ridge of bone, representing the posterior border of the acetabulum, is nearly always present, and that the acetabulum itself is often of considerable size and depth. If the head of the bone is forced over this ridge, and the capsule sufficiently stretched to allow the head to come in contact with the yielding cartilage and other tissues partly filling the acetabulum, the weight of the body thrown on the limb in standing and walking gradually enlarges it to its normal size. The great advantages of such a bloodless operation are obvious:—

1. Hospital treatment, or even confinement to bed, is unnecessary.
2. As the patients are using the limb during the progress of the treatment, the atrophied muscles take on normal function.

3. Parents consent readily to the operation, and cases can thus be treated early.

Children of more than six years of age are not favourable subjects, but it may be performed as early as eighteen months.

Injection Treatment of Hernia.—Feid (*Cincinnati Lancet Clinic*) says that many objects are gained by this injection treatment, especially the following:—

The patient's horror of an operation is overcome by the facts that no knife is used, and he is not confined to his bed.

The comparative absence of danger to life.

The fact that one accomplishes the same result that is obtained by use of the knife, through complete obliteration of the canal, by virtually the same means—viz., local inflammation and deposit of plastic material.

The method of procedure is usually as follows: Remove the hair on the affected side, and then carefully cleanse the part with soap and water, as for any other surgical operation. Insert the index finger into the canal, taking care to push back into the abdomen the contents (if any); insert the hypodermic needle directly into the canal and at right angles to it, beyond the tip of the finger, where it can be felt and the needle guided. It is important that the fluid be injected into the canal, and not

into the surrounding tissue. The inflammation which often follows the injection of the fluid into the surrounding tissue is the reason, the writer thinks, why this method has fallen into disuse, the inflammatory deposit not being in the right place. He gently injects five to ten drops of the following fluid:—R Zinc sulphate, 15 grains; alcohol, 2 drams; carbolic acid, 30 grains; water, Ad. 1 ounce.

The finger is now withdrawn, and the parts are gently kneaded. The patient will complain of some pain for a few days, but this not usually severe.

A Point in the Treatment of Hemorrhoids.—Sims (*Maryland Medical Journal*, May 7, 1898) ligatures the piles in the usual way, then cuts them off close to the ligature. The cut edges of the mucosa are then sewed together with catgut over the stump, so that the raw surface is entirely covered. By this means the risk of supuration, and the suffering, are reduced to a minimum. An antiseptic dressing is applied. The bowels are moved four days later by salines and an enema. The results of operations thus carried out are most satisfactory.

Obliterative Pericarditis a Cause of Hepatic Enlargement and Ascites.—Obliterative pericarditis is not generally known as a cause of enlarged liver and ascites. As the symptoms of the former are not definite, and the patient only comes under treatment for the latter, a diagnosis of hepatic cirrhosis is made, and the primary disease is only recognised at the necropsy. In the *Boston Med. and Surg. Jour.* of May 19, 1898, Dr. R. C. Cabot has published the following case:—An emaciated boy, aged eighteen years, was admitted to hospital. Six years ago his liver was said to be enlarged, and four years ago he noticed swelling of his abdomen. Occasionally the feet had been swollen. The liver was much enlarged, and reached from the fourth rib to a hand's breadth below the navel; it was apparently smooth, and its edge was easily felt. There were considerable ascites and effusion in the left pleura. The heart did not appear to be displaced. The apex sounds were loudest in the fourth space. There was constant orthopnoea. The abdomen was tapped three times and the chest once. About four quarts were obtained each time from the former cavity and two from the latter. There was never any pain. The patient died at the end of eight weeks from pulmonary oedema and exhaustion. A necropsy showed complete obliteration of the pericardium by firm adhesions, the heart normal in size and the muscular substance not altered, the left lung retracted, airless, and covered with adhesions, the right lung compressed, much fluid in both pleurae, and an enlarged nutmeg liver. The diagnosis of these cases, as stated,

is difficult. In every case of obscure hepatic enlargement, especially in young persons, the heart should be examined for evidence of pericarditis. As the pericarditis is mostly tuberculous, evidence of tuberculosis in other parts will be of some value.—*Lancet*.

Treatment of Fractured Patella.—Ball (*Practitioner*, May, 1898) describes a method of radical operation for transverse fracture of the patella, which may be used in recent cases or in cases which have failed under ordinary treatment. He exposes the joint by a horseshoe flap, and cleans out all blood clot. The edges of the fragments are trimmed, and a periosteal flap raised from each. A wire rope, consisting of eight strands of steel wire, is used, and annealed just before being used. This is passed in two separate pieces, the upper piece passing through the quadriceps tendon, and down each side through the tendinous expansion to the level of the fracture. The lower piece is passed through the ligamentum patellæ, &c., in the same way. The two wires are then tightened and twisted together at the sides, and their ends hammered flat. The periosteal flaps are united by catgut. The author thinks this method as safe as any subcutaneous wiring, while it has the advantage of exposing the parts to view and cleaning the joint thoroughly. He recommends it in all cases where the surgeon is sure of his antiseptic precautions. He quotes a case of six months' duration, previously treated only by rest in bed, where the fragments were separated four inches. After treatment in the way described, the wound healed in a week, passive motion was begun in two weeks, and the patient walked in a month. A subsequent skiagraph showed the fragments united and the wire rope *in situ*. No harm apparently results from the presence of the wire rope in the tissues.

The Treatment of Spasmodic Torticollis.—Dr. Herbert J. Hall (*Boston Med. and Surg. Jour.*, Aug. 18, 1898) publishes two cases: one cured, the other much relieved, by the application of a steel spring, similar to the trouser guards worn by bicyclists, to the back and sides of the neck so as to exert gentle pressure as far forwards as the anterior borders of the sterno-mastoid muscles.

Suppurative Splenitis.—(*Maryland Medical Journal* of August 13.) Dr. B. M. Cromwell describes a case of suppurative splenitis caused by tight-lacing and violent exercise, which was successfully treated by operation. The patient was a strong, healthy girl, seventeen years of age, who in order to escape an impending shower ran for the greater part of a mile on a hot day in August, 1897. After running for some time she felt a pain in her

left side, and reached home in a state of more or less collapse. The pain ceased before she reached home, and did not return until the next day, after which it was continuous. Dr. Cromwell, on examining her two or three days afterwards, found a deep sulcus about the margin of the ribs, and in answer to his inquiries the girl explained that while she was running her corset was loose enough but the band of her petticoat was too short and she had to pull it very tight to button it. Above and below the sulcus there was a marked tumefaction. Percussion revealed dullness over the whole of the left side, extending to near the brim of the pelvis and anteriorly to near the median line of the abdomen. The edge of the tumefied spleen could be plainly felt around the greater part of this dull space. The diagnosis was an enlarged and inflamed spleen, and as no improvement followed the use of iodine ointment and blistering an incision was carried through the abdominal parietes into the substance of the spleen. At first there was a copious flow of bright arterial blood, then a small ribbon of pus was mixed with it, and as the pus increased in quantity the blood diminished until the escaping fluid consisted entirely of pus, which continued to be discharged for many days under the influence of poultices, and for several days after it ceased there was a discharge of serum. The total amount of blood, pus, and serum was estimated at about 30 oz. The girl made a good recovery and is now in excellent health.—*Lancet*.

The Treatment of Gonorrheal Rheumatism.—Dr. Carlton (*N. Y. Medical Times*) says that until within the past two months gonorrheal rheumatism has been the bane of the genito-urinary ward, but since the use of the Esmarch bandage has been instituted, the results have been as brilliant as unexpected. The bandage is applied as follows: If the gonorrheal rheumatism is in the knee, the bandage is applied from the ankle to the lower border of the knee; another bandage is applied above the knee. The bandages are wound sufficiently tight to obstruct the circulation, and left on from fifteen minutes to one hour, according to the tolerance of the patient. Dr. Carlton says the bandages destroy the gonococci, by depriving them of oxygen. After from one to six applications a cure is effected.

Injury to the Ureters in Laparotomy.—Blumenfeld (*Münchener Med. Woch.*, August 2, 1898, p. 992). The author collects previously published cases of such accidents, and adds two from the Munich University Clinic for Women. The accident most often occurs in cases where some sudden bleeding has taken place in the depth of the wound and needed hurried treatment, or where very numerous adhesions have had to be divided and ligatured. It may also occur owing to dislocation

of the ureter from its normal position, in consequence of the growth of a tumour. In some cases the severed ureter has been united by suture and no ill results have occurred. In others, extirpation of the kidney of the injured side has been practised. In one of the new cases reported in this article, the ureter had been included in a ligature, but the force of the urine had dilated it and overcome the obstruction. The patient died of peritonitis. In the second case the lumen of the left ureter was obliterated by the tumour and the left ureter was included in a ligature. The patient died of suppression of urine.

Tropacocaine in Infiltration Anæsthesia.—Now that Schleich's "infiltration anæsthesia" is so largely used, any improvement in the method is of interest. The experiments of J. Custer, jun. (*Münch. Med. Wochenschr.*, August 9, 1898) have shown that the toxic power of cocaine when injected hypodermically depends less on the quantity injected than on the strength of the solution used: thus the same quantity of cocaine in a 0.2 per cent. solution is five times less poisonous than in 5 per cent. solution. This discovery considerably lessens the danger of cocaine poisoning; still, if a substance could be found less toxic, but equally efficacious, it ought to be preferred. This advantage is claimed for hydrochloride of tropacocaine, for its anæsthetic power is fully equal to that of cocaine hydrochloride, and it is nearly three times less toxic. The strength of the solutions of tropacocaine used by Custer are the same as those of cocaine used by Schleich, viz.:—No. 1 solution 0.2 per cent., No. 2 solution 0.1 per cent., the No. 3 (0.01 per cent.) is quite unnecessary owing to the lessened toxicity. The vehicle is a 0.2 per cent. solution of common salt. Custer leaves out the morphine contained in Schleich's solutions, preferring to give it, if required after the operation, as a separate hypodermic injection.

Orbital Injury from Contre - Coup.—Dr. F. E. Cheney (*The Boston Med. and Surg. Jour.*, Aug. 11, 1898) applies this name to injuries of the orbit from a blow on the margin producing comparatively little effect at the point of impact, but followed by deep intra-orbital lesions. As in the cranial cavity these may be hæmorrhages, abscesses, or perhaps fracture. A fracture through the apex of the orbit from a blow on its border is not extremely rare. The following case appears to be an instance. A boy was thrown down, and struck the left eye on a rail. He was unconscious for an hour, and the eye was blind when he regained consciousness. There was ecchymosis of lids and conjunctiva, ptosis, limitation of all movements, and slight proptosis (but not more than could be accounted for by paralysis).

The pupil was dilated and immobile. The media were clear. The retina was œdematous and the seat of numerous hæmorrhages. In about six weeks the ptosis and limitation of movement had almost disappeared, but there was no perception of light. The paralysis of all the ocular muscles would be accounted for by a lesion at the apex of the orbit, and the optic symptoms point to a fracture through the optic foramen. In another case a girl was struck under the left eye with a small stick. After a few hours ptosis began, which became complete; in about a week it improved, and soon disappeared. There were no other signs of orbital injury. The branch of the third nerve to the *lavator palpebræ superioris* was evidently paralysed by pressure of a clot or serous exudation. In a third case a boy received a sharp blow over the left eye. Nothing but pain, which soon ceased, was noticed; but next day ptosis set in, and after a week proptosis. Optic neuritis developed and the proptosis increased, and vision fell from $\frac{10}{10}$ to $\frac{2}{10}$ in three days. An operation was performed and pus was evacuated. All the symptoms disappeared except the ptosis. The counter stroke had evidently produced a breaking down of orbital tissues and abscess, and, as in the preceding case, the point of injury was in the posterior third of the orbit within the muscular cone above the third nerve. The writer refers to difficulty of finding a small collection of pus in the connective tissue of the orbit. In operating he divides the connective tissue freely with a blunt scissors as the safest and surest method.

Use of the Röntgen Rays in the Case of a Child who had Swallowed a Pin.

—Faivre (*Jour. de Clin. et de Thérap. Infant.*, Vol. v., No. 32). A little boy of two-and-half swallowed a pin. Emetics and purgatives failed to cause its rejection, and when seen after five weeks, the child held the head rigidly flexed towards the left shoulder, any attempt to relieve the torticollis causing agonising pain. As no foreign body could be located by palpation or examination by the mouth, the radiograph was resorted to under chloroform anaesthesia. The pin was located behind the posterior faucial pillar, on a level with the pharyngeal roof. On the following morning the child was anaesthetised once more, and the pin readily felt and removed.

Mistakes caused by using the Röntgen Rays.

—Seiz (*Therapeut. Monatshefte*, No. 8, 1898) draws attention to the mistakes which can be made in interpreting the results of the fluorescent screen or the skiagram. These are more likely to arise with the former. In one case a girl, aged thirteen, had an outward dislocation of both bones of the forearm, a skiagram was taken twelve days after its reduction. It showed that

the position of the joint was normal, but that apparently there was a separation of the tip of the olecranon. However, there was no clinical sign of this lesion, and the appearance was doubtless physiological, and due to the fact that the epiphysis of the olecranon was still joined to the shaft by cartilage. Without clinical examination a fracture of the tip of the olecranon might have been diagnosed. In a second case, a boy nine years old, fractured the shaft of the right femur. It united with an inch of shortening. However, the skiagram showed what appeared to be a shortening of nearly 3 inches! After such experiences, Seiz concludes that for a true interpretation of a skiagram a clinical knowledge of the case is necessary. It is also necessary that the distance of the object from, and its position with relation to, the illumination should be known. Although such false impressions are the exception, they might be of the greatest importance, especially in actions for damages, and it is most necessary, both for his own and others' protection, that the surgeon should inspect every skiagram most carefully, before allowing it to be seen.

The Relief of Ocular Pain (*Atlantic Med.*

Weekly, 1897, No. 11).—In a review of the measures for relief of ocular pain, including hot water fomentations, ice cold compresses, leeching, counter-irritation, anaesthetics and analgesics, the writer says that of the coal-tar derivatives, lactophenin is probably the safest, and is quite as efficient as any. In ten or fifteen grain doses, the pain of an iritis is sometimes relieved for hours, long enough to allow the patient to get needed sleep. In glaucoma secondary to a dislocated lens, where all the effect of an iridectomy had been produced by the injury itself, this drug was the only one, save morphia, which gave relief. The pain of herpes zoster ophthalmicus, which is so persistent and severe, was also relieved in great measure by this drug—in one case where morphia failed to produce any alleviation of the suffering.

On testing the Functions of the Organ of Hearing.

—Dr. Eschweiler (*Münchener Med. Wochenschrift*, No. 34, p. 1078) considers the methods of examining the hearing capacity for a simple sound, for different musical tones, and the question of conduction of the sound through the air and through the bones of the skull. The simplest instrument for the production of a constant sound is the watch; and by ascertaining the distance at which the watch is audible to normal individuals, the audition may be indicated by a fraction, the denominator of which represents the normal hearing distance, the numerator the distance at which the sound is perceptible to the patient. As watches differ, Politzer devised a standard instrument consisting of a small cylinder

struck by a hammer with constant force, so that a comparison of the results of different observers is possible, the tap of this instrument being the same in all.

A more important inquiry consists in the question of the patient's capacity for hearing spoken words; for this purpose whispered words are to be preferred. In speech we make use of sounds varying in pitch, intensity, or loudness, and in duration or "presentation-time." This last is important, as is shown by an experiment of Dennert's, who showed that if a vibrating tuning-fork were caused to swing backwards and forwards before the ear at a certain distance, until it ceased to be audible, it was again heard if it were held steady at the same distance, the duration of the stimulus to the ear being thus increased. The capacity of the ear to distinguish the component parts of spoken words is very different, vowels being much more easily heard than consonants, the presentation-time of which is very short, and some vowels more easily than others. For instance, the sound "ah" is more readily perceived than "ee." Again, the ear hears more readily words to which it is accustomed than strange ones, as almost everyone must have noticed in endeavouring to catch words spoken in a foreign tongue. The ordinary distance at which whispered words are audible is put at about 20 mètres, but this estimate errs probably on the side of excess. For active service in the Prussian army a man must be able to hear a whisper at a distance of over 4 mètres, while railway servants must do the same at 7 mètres.

Perception of musical tones is tested by means of a series of tuning-forks, or covered organ pipes, of varying pitch; and this examination is of some importance, as an aid to diagnosis. Perception of high notes generally signifies disease in the internal ear; but the internal ear suffers along with the tympanic cavity in a larger proportion of cases than is generally recognised. It is interesting that many apparently sound persons have defects of hearing for certain tones, while deaf mutes often possess hearing capacity for certain tones.

Œsophagotomy practised on a Child in order to extract a Coin which had been located by the Radiograph.—Dr. M. L. Monnier (*Gazette Médicale de Liège*, August 26, 1898) reports the case of a child of five years of age who swallowed a coin about the size of a franc. Catheterisation under chloroform caused the cessation of the intense dysphasia that followed after, but did not enable them to locate the coin. The first radiograph showed the coin placed vertically, and arrested at the point of junction of the third and fourth vertebræ. The second radiograph showed the coin to be on the anterior wall. Dr.

Monnier taught the child to tolerate a rubber sound introduced by way of the nose to the upper third of the œsophagus. At the end of a week he performed external œsophagotomy, which enabled him to reach the piece of money with the left index finger introduced into the œsophagus by an opening of from eighteen to twenty millimètres. With the aid of his nail he disengaged the coin, and with ordinary nasal forceps drew it out.

The results of the operation were very satisfactory. The nasal sound was removed on the fifth day, and by the fourteenth day the œsophageal wound was healed.

The Treatment of Hydrocele by Incision and Eversion of the Tunica Vaginalis.

—Surgeon-Major Pratt (*Indian Med. Gaz.*, Aug.)—The writer has successfully treated a large number of cases of hydrocele by incision of the parietal layer of the tunica vaginalis; but in this operation there is some danger of recurrent hæmorrhage. He has, therefore, introduced the following operation, which is without this disadvantage.

An incision is made along the whole length of the scrotum in its long axis, the tunica is exposed, and the testicle is almost entirely withdrawn from the scrotum. The tunica is punctured with a knife, the puncture is enlarged with the scissors, and the testicle is drawn out through the opening. The parietal tunica is then turned inside out, and the opposite edges of the incision united behind the epididymis by catgut. The skin incision is then closed.

Removal of a Bullet from the Brain, located by the Röntgen Rays.

—Braatz (*Cent. F. Chir.*, 1898, No. 1.) reports a case in which a bullet was removed from the brain substance, the patient making a complete recovery. The symptom most complained of was an intense pain when the head was held to the left side. After a number of skiagraphs had been taken, one was obtained which showed the bullet in the anterior portion of the brain.

The first operation consisted of the formation of a bone and integument flap by means of Gigli's wire saw, the opening being increased in size by the use of rongeur forceps. The bullet, however, was not found even after the dura was opened and the brain palpated. The difficult breathing of the patient necessitated a cessation of the operation; the wound was closed, and healed by primary union.

The pain continued. A series of skiagraphs were now taken, but it was impossible to get a picture in the antero-posterior direction. In all of these Reed's base line was marked by lead wire, and showed in the skiagraph. At length, by placing the plate at an angle on the left temporo-frontal region, a skiagraph was obtained from a

second point, which showed the bullet. In this case a lead wire was placed above the nasal bones, so that this point was readily determined.

A second shadow, which was due to a fragment of lead upon the opposite side of the cranial cavity, was also shown, and from these points and their relations, it was roughly determined that the bullet lay deeper in the brain substance than at first supposed, and anterior to the opening made in the first operation. This rough method of determining the location of the bullet, crude compared with mathematical methods now employed, served the purpose of guiding the operator to the successful removal of the bullet in the following manner:

The bone integument flap formerly made was again removed, also the dura mater. A blunt needle was now employed as a probe, and the brain was punctured in the direction of the bullet, which was finally located. A dull fruit knife was then passed along the needle, thus minimising hemorrhage, and with a pair of closed Kocher's forceps the bullet was finally removed. The patient made an uninterrupted recovery.

Iodoform in Tuberculosis of Joints.—Briegel (*Beit. z. Klin. Chir.*, B. 20, 1898) in thirty-nine cases of tuberculosis involving the wrist, treated by iodoform injections after the manner originated by Burns, twenty-four were permanently cured, while, with fifteen others, measures had to be resorted to—such as resection, amputation, &c. In those cured the functional results were excellent, far better than after resection. The iodoform was used in the form of an olive-oil emulsion of a strength of 10 to 20 per cent., and in the granulating form of the malady from 30 to 120 minims were injected; but where abscesses had been emptied, from 3 to 9 drachms were employed. The number of injections varied from one to twenty-eight, and usually from three to seven were required. Even cases in which abscesses and fistulæ had formed were amenable to treatment. Absolute asepsis must be maintained.

Treatment of Chronic Ulcers of the Leg.—V. Langsdorf (*Cent. F. Chir.*) has found that the following method results in rapid and permanent healing. He first washes the entire leg with soap and water and carefully dries it; then the area of the wound is covered with calomel converted into a thick paste by mixing with water. Over this paste salt is strewn and thoroughly mixed in; a gauze and cotton dressing is then applied. The action of salt upon the calomel produces sublimate. This nascent sublimate is very active, and for three or four hours produces an intense burning, which gradually subsides. After twenty-four hours the wound is dressed and found dry, free from

unhealthy granulations, and perfectly aseptic. The pain which accompanies the inflammation and infection in the surrounding skin margins is almost entirely cured by this dressing. The application of unguentum basilicum, with rest in bed, produces a speedy covering of the wound with new skin. Exuberant granulations are touched with crystals of copper sulphate. After complete cicatrisation, the whole lower leg, including the foot, is placed in a fixed dressing for two weeks. The new skin is very firm, and has not the tendency to break down which is so often seen after other forms of treatment.

Air Infection.—Flügge (*Cent. F. Chir.*), in tracing the sources of error in aseptic methods of operation, records some very interesting results obtained from the experimental study of infection from bacteria in dust particles and in minute particles of moisture floating in currents of air in operating-rooms. These dry particles and drops of moisture are carried by the currents in the room long distances. It was determined that such drops from infected mucous membranes of the nose and throat could be discharged into the air by coughing and sneezing—even talking loudly would infect prepared plates at a considerable distance from the speaker. Although the author does not claim that this is the most frequent source of infection in cases of aseptic wound treatment, he maintains that it is more plausible as a theory than to attribute all such infection to defective antisepsis of the skin in the field of operation. Infection through the air may therefore be a possible explanation of many cases of infection hitherto unaccounted for.

The Creation of New Joints between Bones which are normally independent.—In a recent communication to the French Academy of Science (*Gazette des Hôpitaux*, June 13, 1898), Professor Ollier of Lyons lays down the principles upon which a new joint may be created between bones which are normally independent or which, at any rate, do not articulate with each other. By fixing the bones to each other, preserving not only the tissues which will assure their union but also the remains of any muscles which act upon the joint which has been lost or destroyed, a new joint may be obtained, surrounded by muscles which may confer upon it active functions. In a recent case, Ollier attached the upper end of the decapitated humerus to the outer end of the clavicle, and succeeded in restoring the functions of the upper arm. The head of the humerus and the entire scapula had been lost, as the result of a gunshot injury sustained at the siege of Metz in 1870. The upper limb was only connected to the trunk by soft parts, the upper arm hung useless by the side. The outer

end of the clavicle was dragged upwards by the trapezius, and had lost all relationship with the humerus. There was a depressed gap between it and the upper end of the humerus, which measured 8 cms. In spite of a special apparatus supporting the elbow, and fixing it against the trunk, the patient could not undertake any manual occupation. The operation was performed by Ollier on December 23, 1893. The adjacent ends of the clavicle and humerus were bared of periosteum, the latter being preserved. The bones were fixed to each other by two platinum wires, which were left *in situ*. A fibrous ankylosis resulted, with considerable movement in all directions, but especially free in the antero-posterior plane. Special attention was paid at the operation to the reconstruction of the muscular attachments; the deltoid was disengaged from its cicatricial connections, and was sutured to the trapezius at several points, so as to form a digastric muscle. The other muscles were similarly dealt with, so as to reproduce around the new joint a muscular system, as nearly like that of the original shoulder-joint as possible. The wound healed under one dressing. The limb was immobilised by a plaster bandage for four months. Although at first very stiff and useless, the joint now enjoys a very free range of movement. The bones are so well fixed to each other that the patient can lift weights from the ground with the same facility as with the opposite limb, and can abduct the upper arm at the shoulder with considerable energy. The clavicle is no longer dragged upwards, but lies in the same plane as the corresponding bone on the left side. Since the operation, the patient no longer uses his complicated apparatus, and is able to use his arm for all ordinary purposes.—*Edinburgh. Med. Jour.*

Injuries from the Improper Treatment of Foreign Bodies in the Ear.—R. Haug

Deutsche Med. Woch.) reports another case illustrating the evil results of trying to remove a foreign body, a carob-bean, from the ear by means of forceps and hooks, instead of by syringing. When Haug saw the patient on the ninth day, the auditory canal was in a high state of phlegmonous inflammation, the auricle and surrounding region were swollen, and the cutis of the osseous part of the auditory canal was torn out by unskilled manipulation, so that the periosteum was exposed. By means of a probe the foreign body could be felt firmly imbedded, but could not be seen through the swollen and closed canal. Pain in the ear and mastoid increased, and headache, vertigo, nausea, and fever set in. As it was impossible now to remove the swollen bean through the inflamed and narrow meatus, the auricle was detached behind and thrown forward, when it was found that the foreign body had been pushed through the membrana tympani into the drum cavity, and rested

upon the promontory, where, by reason of the swelling of the bean from the constant bath of pus in which it lay, it was firmly wedged, and was removed only after chiselling off a portion of the osseous canal near the membrana. Entire recovery took place in two months.

Excision of the Cæcum for Tuberculous Disease.—Dr. H. A. Lediard

(*The Lancet*, Aug. 13) describes a case of this rare operation. A man aged sixty-three years was admitted to hospital on account of a hard swelling in the right inguinal and hypogastric regions. He had been ill for eight months, and suffered from looseness of the bowels. The swelling was in as well as beneath the parietes, and not mobile. A reddened patch appeared, and an incision was made, and pus evacuated. Fæcal matter was discharged, and there was a sinus which led from below, and to the right of the umbilicus, towards the anterior superior iliac spine. Pus and fæces were discharged for some months. The sinus was laid open, and traced down to the cæcum, which was found adherent all round, and having thick and hard walls. The cæcum was excised, and the ileum was attached to the wound, whilst the lower end of the colon was closed. The sinus was scraped and stitched up, and the wound healed. Microscopic examination showed the disease to be tubercular. The patient's condition was too feeble to admit of entero-anastomosis. The cæcum has been frequently excised for cancer, but seldom for tuberculosis.

Heteroplastic Bone Grafts.—Dubar (*Jour. de Clin. et de Thérap. Infant*, Vol. v., No. 50). On account of tuberculous osteo-arthritis involving the right wrist, in a little girl of five years, the joint was laid open, the diseased portions removed, and five pieces of bone from the femur of a young dog (killed when the operation began) were inserted in place of the five wrist bones which had been taken out. The wound healed well, there was no pain, and in three months the right hand could be used to hold light objects.

Six-and-a-half years later the joint was straight, firm, movable, and very useful.

Radiographs were taken of both wrists in order to determine what had become of the pieces of grafted dog's bone. It was plain from these that the bone grafts had not been absorbed, but remained surrounded by a mass of new-formed fibrous tissue which united them to the *débris* of the carpal bones; they had also increased in size. Whether the original pieces of transplanted dog's bone remained as such, and even increased in volume, or whether they were absorbed after acting merely as a stimulus to the new formation of bony tissue in the child's wrist, has not been satisfactorily decided.—*Arch. Pediatrics*, Vol. xv., No. 6.

GYNÆCOLOGY.

Primary Tuberculosis of the External Genitals.—Paoli (*Sem. Gyn., La Gynécologie*) quotes five cases of this affection, which he regards as less rare than is commonly supposed. He believes that the disease is frequently communicated directly during coitus, the primary site being in the region of the vestibule, whence it extends gradually to the surrounding tissue.

It is distinguished clinically by ulceration and hypertrophy of the labia. It runs a chronic course, and remains localised for a long period, the general health being but slightly affected. The inguinal glands are not often involved, contrary to the prevailing opinion. Microscopically, intense congestion and inflammatory infiltration are noted, caseous degeneration is rare, and spontaneous repair is the rule.

Secondary tuberculosis of the external genitals extends more rapidly, and exhibits a more malignant character. Treatment is surgical, extensive resection of the affected tissues being necessary. A considerable portion of the urethra may be removed without injurious results.—*Amer. Jour. Med. Science.*

Precocious Puberty.—De Vlaccos (*Ann. de Gynéc. et d'Obstét.*, March, 1898) gives a full report of a case, with a photogravure. She was born in August, 1892, and had all the appearance of a child aged ten, excepting that as far as the genital and mammary regions are concerned she was yet more developed. In height she measured 3 ft. 8 in.; her weight was 3 st. 8 lbs. The hair of her head was very abundant, whilst her intellectual development was not above her years. When six months old a bloody vaginal discharge was noticed, and it returned in about six weeks. The interval steadily became shorter, and the catamenia became monthly, lasting for about four days, the child becoming depressed in spirits at each period. The mammae resembled those of a girl of seventeen, and not only had hair grown on the pudenda, but much subcutaneous fat developed in the region of the thighs and nates as normally occurs at puberty.—*Brit. Med. Jour.*

Foreign Bodies in the Uterus.—Mittermaier (*Centralbl. f. Gynäk.*, Leipzig, Dec., 1897) reports two cases. 1. A multipara, aged 30, complained of a foul-smelling leucorrhœal discharge. A year previously she had had a submucous fibroid removed, when a silk suture was passed round the pedicle, and the tumour cut off below it. On examination, the uterus was found to contain several fibroids, and there was also double pyosalpinx. Vaginal hysterectomy was performed, and at the orifice of the right tube a small submucous fibroid was found, with a silk

ligature round its pedicle, which had been drawn into the uterine cavity by the retraction of the remaining portion of the tumour, and had thus been the cause of the salpingitis.

In the second case, a glass catheter which had been used for irrigating the uterine cavity after curetting, had broken off and the fragments became imbedded in the uterine wall. After dilatation of the cervix, and ineffectual attempts to remove the fragments, the uterus was drawn into the vagina through an incision in the anterior vaginal wall, and the anterior uterine wall split from cervix to fundus, when five fragments of glass were found embedded in the mucous and muscular coats. These were removed and the wound was sutured with catgut. Healing took place by first intention.—*Edinburgh Med. Jour.*

The Therapy of Vulvo-Vaginitis in Children.—J. Comby (*Allgemeine Wiener Medicinische Zeitung*). The author believes that vulvo-vaginitis is more common than usually thought in young children, and he has collected 150 cases, besides referring to other reports also giving large numbers. Contagion in many cases has been direct from a mother or older sister, and the child being infected by the discharges on the bed-linen, from the same bath, or sponge. He cites one instance in which infection was due to a bath thermometer, another by direct infection at birth, from purulent ophthalmia, while in many other cases it has been from young boys suffering from gonorrhœa. He divides the cases due to vulvo-vaginitis gonococcica from those due to oxyuris, pediculosis, streptococcus, staphylococcus, bacillus coli, &c. Those cases of vulvo-vaginitis occurring with fever and other diseases are often due to a lack of cleanliness. The urethra and bladder often become involved while endometritis, salpingitis, even peritonitis may result; rheumatism may also follow as in cases of ordinary gonorrhœa. In cases where the genitals are swollen with considerable erythema, dysuria, and pain, he recommends that the child be put to bed, its diet light (consisting of milk or soup with little or no meat) and the genitals washed with a boric acid solution 3:100, or bichloride solution 1:4000, and afterwards powdered and then protected by a tampon. This should be done after each urination. Care should be taken that discharges do not collect in the genital folds or back of the hymen, as this is often the cause of failure in the treatment of these cases. If irrigation of the vagina is necessary, it may be done with a small canula or a Nelaton's catheter, using sterilised water or a weak boric acid solution. In some cases a solution of potassium permanganate 1:2000 or bichloride 1:10,000-5000. In protracted cases a small quantity of a solution of silver nitrate 1:100 introduced into the vagina with a small syringe often proves

effective, and in some other cases where douching is ineffective a suppository of iodoform solution and creolin 10:100. If the urethra is involved, it should be treated carefully until the mucous membrane is perfectly healthy, for if any foci are left it is sure to give rise to fresh infection. Where the urine contains pus and blood and shows signs of a cystitis it should be irrigated with a boric acid or nitrate of silver solution, and any tumor of the mucous membrane should be treated according to the rules of surgery. He mentions peritonitis and salpingitis as grave complications. He recommends that all articles used by persons having gonorrhoea be placed out of the reach of children. The toilet and bath should be kept separate, and children affected with this disease should not play with other children not affected, especially in institutions. In the simple or non-gonorrhoeal, cleanliness, with constitutional remedies for debilitated, will decrease the tendency to this malady.—*Internat. Med. Magazine*.

OBSTETRICS.

1. Repeated Cæsarean Section in a Case of Spondylolisthesis.—R. Braun v. Fernwald (*Centralbl. f. Gynäk.*, Leipzig, 1898, No. 19) reports a case where the under surface of the last lumbar vertebra covered the anterior part of the first and a great part of the second sacral vertebra. The obstetrical history was:—

1. Pregnancy ended in turning and extraction of a dead fetus.
2. Induced labour with forceps.
3. Ended at eighth month.
4. Abortion.
5. Cæsarean section.
6. Abortion induced at the third month.
7. Second Cæsarean section and extirpation of uterus.

At the second Cæsarean section the uterus was opened into by Fritsch's oblique incision, and afterwards removed, with retroperitoneal treatment of the stump. The anterior uterine wall was very thin; and Braun-Fernwald mentions this as a possible cause of rupture of the uterus in cases where pregnancy occurs after a previous Cæsarean section. He objects to castration only, as the uterus without the ovaries is a worthless organ, and he would prefer removing both. Ligature of the tubes only is useless, as Falaschi and Fritsch have both reported cases of pregnancy following this method. Kehrer divides the tubes through a vaginal incision; but against this method is the possibility of subsequent union; and Fritsch's method of removing 1 cm. of tube tissue between the ligatured portions is no guarantee against the occurrence of a subsequent extra-uterine pregnancy. Braun-Fernwald divides the uterine ends of the tubes between two liga-

tures, and turns in the uterine stump on both sides under the peritoneum, and sutures the latter over the ends.

Rühl adopts a similar method through the anterior vaginal wall, and sutures the ends of the tubes to the vaginal mucous membrane.—*Edinburgh Med. Jour.*

The Management of Brow-presentations.

—Solowieff (*Centralbl. f. Gynäk.*, No. 30, 1898) reports that he has used a manipulation proposed by him ten years ago for converting brow into face-presentations in eighteen cases, and that it succeeded in five. It consists in passing the examining finger along the face, until the mouth is reached. The first phalanx is then hooked on to the alveolar ridge of the superior maxilla, and traction is made downwards towards the brow. This produces extension of the head, and must be continued until the face has fully engaged in the pelvis. For success, the following conditions are necessary:—(1) There must be no disproportion between the size of the head and the pelvis; (2) the os must be fully dilated; (3) the amniotic fluid must not have escaped long before; and (4) there must be sufficiently strong pains. When possible, the advantages are: (1) its simplicity; (2) nothing can be wounded, while this is very likely to happen during turning; (3) the very slight danger of infecting the mother; (4) the possibility of performing it without chloroform, or further assistance; and lastly (5), the comparatively early termination of the labour.

First Menstruation and Pregnancy in Middle Life:—Dr. J. Wolfe (*The Lancet*, Aug. 6) publishes the following case, which appears to be unique. A married woman, aged forty-three years, who had never menstruated, was frightened by an idiot, and menstruation commenced on the same day, and lasted two or three days. She became pregnant and had a normal labour at the age of forty-five. Between the first menstruation and impregnation she menstruated occasionally, but not regularly.

A Fatal Case of Hæmorrhage under the Scalp in a New-born Infant:—C. W. Townsend (*Boston Medical and Surgical Journal*, March 3, 1898) reported this curious accident. After a short first stage of four and one-half hours, and a second stage of two hours and fifteen minutes, a child was delivered with forceps, because of lack of progress and what was thought to be a large caput succedaneum. After the delivery the supposed caput instead of decreasing became larger, and was found to be soft and fluctuating; it was due evidently to an effusion of blood. On the third day it was still larger, extending over the whole cranium. The

infant was pale, and its rectal temperature was only 96.8 deg. On the seventh day the tumour was still increasing, extending over the frontal bones and down the sides of the skull. Death ensued on the tenth day.

At necropsy the body was greatly blanched. A firm blood-clot extended under the scalp and above the periosteum (thus differing from a cephalhæmatoma) over the entire cranium, three-quarters of an inch thick in places. This clot reached from the foramen magnum behind to the middle of the frontal bones anteriorly, and down to the ears on both sides. The child had bled to death under its scalp. It was impossible to find the source of the hæmorrhage, but there seemed to be several points of origin. No hæmorrhages were found elsewhere.—*American Jour. of Med. Sciences.*

The Mechanism of Labour.—G. Porter Mathew, M.D. (Cantab.). Notes abstracted from a thesis written for the degree of M.D., remarks on the mechanism of labour:—

In occipito-anterior cases we are taught that the head is born by a movement of extension. This statement ought to be qualified. I have convinced myself by examination per rectum that the chin does not leave the sternum until the major diameter of the head passes the vulval outlet; in other words, the head progresses by a gliding movement until the sub-occipito-bregmatic diameter has passed. Extension now takes place by the elastic action of the stretched perinæum on the slope of the forehead. This point is obviously of the utmost importance, for in forceps delivery where axis-traction forceps are not used, if the handles are carried forward as soon as the occiput appears under the pubic arch—and this is common practice—the head is forcibly extended by leverage before natural extension should take place; consequently a greater diameter than that intended by nature passes over the perinæum, and rupture of the latter takes place.

Diphtheria of the Vulva.—Dr. J. Whitridge Williams (*The Amer. Jour. Obstet.*, Aug., 1898) observes that in necropsies made on cases of puerperal fever dirty greyish or yellowish membrane is frequently found in the uterus, on the vaginal walls, and on tears about the vulva, vagina, or cervix. This condition has been described in the older works as diphtheritic, but the great majority of the cases are due to superficial necrosis, produced by the streptococcus alone or in combination with other organisms. Very few cases have been recorded in which the diphtheritic nature of the membrane was proved by the finding of the bacillus. Dr. Williams describes the following case:—A woman aged

twenty years began to complain of pain and swelling of the vulva on the twelfth day of a normal puerperium. The inner surface of both labia majora and minora was covered by greyish-white adherent membrane which extended a short distance up the vagina. The diphtheria bacillus was found. Antitoxin was given, and the genitals were cleansed with boracic acid solution; the membrane rapidly disappeared. The infant and an elder child were attacked after the onset of the disease in the mother and died. They appear to have been infected by her.

A Rational Method of Relieving Asphyxia in the New-born Infant.—Dr. S. Stringer (*Jour. Amer. Med. Association*) recommends that in cases of asphyxia the funis should not be severed, but the placenta immediately delivered, cleared of clots by means of hot water, and freely exposed to the air. He asserts that circulation will go on for several hours, and that by this method many children can be saved who must otherwise perish. The idea is that atmospheric aëration goes on, and that intra-uterine life is prolonged outside. The method seems worth a trial.

Pregnancy after Hysteropexy.—Gibert (*L'Obstétrique*) is of the opinion that ventral fixation of the uterus entails no trouble should pregnancy occur, provided that the anterior and upper part of that organ be fixed to the abdominal walls. The common error of the operators is to fix the top of the fundus at the level of the insertion of the tubes low down and close over the bladder. The cervix is thus brought upwards, lying unnaturally high and very far back. When pregnancy occurs it is only the posterior wall of the uterus that can develop. In one case, where the fundus was thus fixed, the foetal head lay in a natural attitude, though the height of the cervix was awkward for the obstetrician. The shoulders, however, lay in a big pouch to the left, separated from the head by a kind of spur. This pouch was the left half of the back of the uterus, which had developed very irregularly. Turning was effected with difficulty; as the shoulders were delivered the uterus straightened itself, and it was found afterwards that it had broken away from the adhesions. The child was saved. When the front of the uterus is well opposed to the parietes the entire organ can develop during gestation, the cervix is not inconveniently placed at labour, and the anterior adhesion remains intact after delivery. Gibert describes a case in which this satisfactory result ensued. Involution was rapid, whilst in the first case the detached uterus apparently maintained its deformed condition.—*British Med. Jour.*

BOOKS REVIEWED.

ELEMENTS OF PHARMACY, MATERIA MEDICA, AND THERAPEUTICS. (By William Whitla, M.A., M.D.)—London: Henry Renshaw. Seventh Edition. Price 10s. 6d.

Praise of this well-known work is superfluous. When we say it is all that a text-book should be we have not said too much. The student preparing for examination will find it invaluable, and, the drugs being placed in alphabetical order, it will also be useful as a work of reference. The section on non-official remedies should be particularly interesting to the general practitioner in these days of progressive medicine.

The author deals very fully with the section on pharmacy about which the average student knows relatively little when he graduates.

All the new official drugs and preparations are included in this edition, so that it will be found up to date.

OUTLINES OF PRACTICAL SURGERY. (By Walter G. Spencer, M.B., M.S., F.R.C.S., Surgeon to the Westminster Hospital.)—London: Bailliere, Tindall, & Cox, 1898. Price 12s. 6d.

To condense into one volume, in a readable and practicable form, the vast field of surgery, calls for not only an intimate and exhaustive knowledge of surgery in all its branches, but a talent for presenting the cardinal features of a subject in the fewest possible words without loss of clearness, a genius for brevity. Dr. Spencer has succeeded where many have failed. In every sense this work is a valuable contribution to medical literature, and will be found not only of great value to the student of medicine, but to the general practitioner as well.

When the book is taken for what it is intended, an outline of practical surgery, it calls for only the most favourable criticism. It is well printed in large type, and the illustrations are excellent. The index leaves but little to be desired. The book is certainly one worth purchasing, and deserves a wide circulation.

ASEPSIS AND ANTISEPSIS. (By H. MacNaughton-Jones, M.D., M.A.O., M.Ch.)—London: Bailliere, Tindall, & Cox, 1898. Price 3s.

This short work will be found useful to the many practitioners who have to operate in their patients' home, where the surroundings as a rule are not sufficiently aseptic. It deals with the following points: installation in the private home; the various aseptic appliances required; the methods of sterilising of dressings, sponges, gut, and silk; the different antiseptic solutions and dressings; the preparation of the surgeon, assistants, and nurses before operation; the rules to be observed by the nurses; the preparation of

the patient, and the conduct and toilet of an operation.

A short space is also devoted to notes on the methods of various eminent surgeons.

AIDS TO MATERIA MEDICA AND THERAPEUTICS. PART II.—London: Bailliere, Tindall, & Cox, 1898. Price 2s. 6d.

For the student wishing to refresh his memory for examination, this little book will be useful.

The characters, dose, officinal preparations, and therapeutics are given in a brief and readily accessible form.

AIDS TO MATERIA MEDICA. (By William Murrell, M.D., F.R.C.P.)—London: Bailliere, Tindall, & Cox, 1898. Price 2s. 6d.

As the author of this small treatise states in his preface, "Materia medica is not usually considered an attractive subject, but as it has to be taken, it is best to take it like pills—in the smallest possible compass." He has admirably succeeded in compressing a large amount of information into a very small space.

THE DIAGNOSIS OF DISEASE. (By J. Porter Parkinson, M.D., M.R.C.P., Lond., F.R.C.P. Eng.)—London: Bailliere, Tindall, & Cox, 1898. Price 4s.

The diagnosis of disease is generally recognised to be the pons asinorum of a medical student, and the present volume has been written with the intention of helping him in his difficult task and of refreshing the memory of the practitioner; the writer has admirably succeeded in his object.

A MANUAL OF HYGIENE FOR STUDENTS AND NURSES. (By John Glaister, M.D., D.P.H., Cantab.)—London: The Scientific Press, Ltd., 1898. Price 3s. 6d.

This book, which is ostensibly for nurses and students, should be read by many practitioners and laymen as well. The author sets out clearly and concisely many facts which should be impressed upon the public, especially upon those living in large centres. It is a most useful and practical book.

THE CARE OF CONSUMPTIVES. (By W. H. Daw, M.R.C.S.)—London: The Scientific Press, Ltd., 1898. Price 1s.

This is a small book written for the use of nurses. It will give them much useful information about the disease, and the knowledge to be gained by a careful study of this small treatise will make their work more interesting and valuable.

LECTURES ON THE THEORY AND PRACTICE OF VACCINATION. (By Robert Cory, M.A., M.D., Cantab., F.R.C.P., Lond.)—London: Bailliere, Tindall, & Cox, 1898. Price 12s. 6d.

This book comes at an opportune moment, when the subject of vaccination is receiving such widespread attention, and when it is con-

spicuously evident that certain ill-advised opponents of Jenner's great system of prophylaxis have exerted such disastrous influence upon our national legislature.

The author, whose authority on this subject is great, has treated the subject very fully, and the book is admirably illustrated.

CANCEROUS AND OTHER TUMOURS. (By Herbert Snow, M.D., Lond.)—London: Bailliere, Tindall, & Cox, 1898. Price 5s.

The practitioner will find this book a useful addition to his library. The author gives the result of his long experience of cancerous growths; and though his views largely conflict with the established theories, his arguments are strongly supported by the facts presented. He asserts that: "All who, with adequate opportunity, have studied malignant disease in the light of recent pathology, concur in recognising the perfect and permanent curability of cancer by scientific surgical methods employed under certain conditions."

The author maintains that cancer is not, as generally supposed, constitutional, but the malignant growth is a disease of the central nervous system, and therapeutic improvement can only follow research on this line, *i.e.*, among "neurotic" drugs—*e.g.*, opium and cocaine. He states that there exists strong grounds for regarding the causation of the disease as non-microbic, and much positive evidence can be found in favour of the autositic theory. This theory "ascribes cancer to a reversion of the natural cells or cell-elements to that primitive amœbiform condition from which all have emerged, and in which a few still persist. Each cell then casts off its allegiance to the nerve-centres, which cease to exert over it the least control. It becomes a quasi-independent parasite, or rather autosite.

"The malignant or 'cancer'-cell now preys, exactly as a parasite would, upon the healthy parts around, appropriating the nutriment destined for them. Its life is not as their life, and involves, sooner or later, their death. Ultimately it brings about the somatic death of the whole organism."

The treatment by the extract of fresh lymph glands will be watched with interest.

It is a well-written, instructive book, affording much food for thought.

MANUAL FOR STUDENTS OF MASSAGE. (By M. A. Ellison, L.O.S.)—London: Bailliere, Tindall, & Cox, 1898. Price 3s. 6d.

This book is written for students of massage, a therapeutic agent of much value in proper hands. The chapters on anatomy and physiology—a knowledge of which is so necessary to a masseuse—are simple and accurate, and the book is well illustrated.

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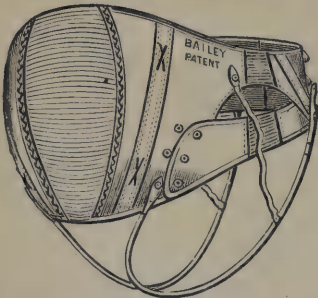
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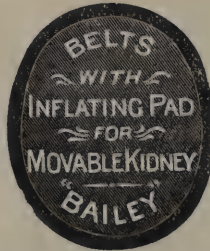
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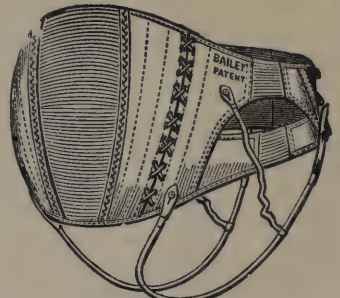
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NOTES.

The fatal outbreak of a secondary form of Asiatic plague at Vienna has occasioned needless anxiety, other cases of accidental infection in European laboratories having previously occurred without being followed by any extension of the disease. The measures so promptly taken at Vienna to prevent further infection have been effective, and there is little likelihood of the plague becoming epidemic in Europe. Two years ago, three sailors on a ship in a London dock were found to be affected with the plague, and were successfully treated in one of the metropolitan hospitals. In the present year a passenger steamer from Bombay landed a plague patient at Southampton, where he was treated in a local hospital without the infection spreading. Bacilli obtained from the three sailors were sent to the Pathological Institute at Vienna. The fact that isolated cases of Asiatic plague are from time to time found in various European and American ports without being followed by a general epidemic of the disease, should remove the apprehension to which the Vienna outbreak has given rise. It may be safely assumed that there is no probability of there ever again being anything approaching an extensive outbreak of the plague in a civilised country. The resources of modern science render such a danger practically out of the question. It is to be hoped that the scientific and beneficial work undertaken at Vienna will not be interrupted. Whilst it is true that modern science has largely robbed the plague of its former terrors, it is none the less

necessary that every possible precaution should be exercised. Various sensational statements have appeared in the Press which, if based upon facts, indicate culpable negligence on the part of the authorities, at Vienna, prior to the infection of the attendant Franz Barisch.

The heroic death of Dr. Hermann Müller, which occurred in the Hospital for Infectious Diseases at Vienna on the 23rd of last month adds another name to the list of victims of the science of bacteriology. Last year Drs. Müller, Albrecht, Ghom, and Poech were sent out to India to study the plague, and they brought back with them a supply of bacilli cultures, with which they have recently been experimenting at the Vienna Pathological Institute. On Saturday, October 15, Franz Barisch, the attendant who had charge of the animals used for inoculation, became suddenly ill, apparently suffering from influenza or pneumonia. Dr. Müller attended him, and although the manner of infection could only be inferred, suspected plague from the nature of the symptoms. Examination revealed the presence of plague bacilli, and Barisch was at once isolated. To prevent further infection, the two nurses, who, besides the doctors, were attending Barisch, were also isolated in a separate wing of the Francis Joseph Hospital. Barisch died in about three days. Dr. Müller, and Nurse Albertine Pecha soon developed symptoms of the disease. Dr. Müller died within a little over forty-eight hours. Nurse Pecha's condition improved for a time under the Pasteur serum treatment, but she died within a few days.

The characteristic swellings of the lymphatic glands were not present. The patients at first felt feverish, afterwards sick, and pneumonia with a high temperature supervened. This pneumonic type, without glandular swelling, is not uncommon in India, and is quite as fatal as the so-called bubonic type. The rarity of cases among nurses and doctors attending the plague-stricken natives in India proves that, with suitable precautions, infection can generally be avoided, and it will probably be found that, at Vienna, there was some fault in the arrangements. Conducted with care, experiments with even the most virulent cultures are not commonly considered dangerous. Manifestly bacteriological investigation of diseases such as the plague must always be attended with a certain amount of danger for the investigator, but if men and women are willing to risk their lives in the interests of humanity and science, it is absurd, in the circumstances, to suggest prohibition, as some have done, on behalf of the outside public, for whom such experiments are made.

It is reported from Vienna that the use of Pasteur's anti-plague serum is meeting with successful results. With the exception of Nurse Pecha, who was inoculated with the serum five days after the beginning of her illness, none of the persons inoculated have developed the disease. According to the *St. James's Gazette*, Dr. Müller, who had treated some 300 cases of the plague in India, did not believe that any success would result from the use of the plague serum. Dr. Müller describes the symptoms as follows:—"Violent headache, stupor, delirium, and extreme giddiness, causing the patient to walk like a drunken man. The illness generally appears suddenly and without previous symptoms, the pulse occasionally ranging from 160 to even 200 per minute. The pneumonic type is much more difficult to diagnose than the bubonic. Consciousness is generally retained until death. The quantity of bacilli in the

body is enormous, said to be greater than in any other infectious disease."

The *Times* states that the Governor-General of Russian Turkestan has officially reported an outbreak of an epidemic, believed to be the plague, at a village in Samarkand. The place has been isolated, the linen of those who have died has been burnt, and the village has been disinfected. Experienced physicians and bacteriologists, who have studied the plague in India, are, by order of the Czar, about to start for Samarkand (with Prince Alexander of Oldenburg, patron of the Institute of Experimental Medicine at St. Petersburg) to superintend the measures being taken for the localisation of the disease.

In the city of Bombay the plague continues to decline, the returns for the week ending November 1st showing a distinct improvement. The present recrudescence of the epidemic, which has existed since July of this year, has not shown a tendency to increase since the advent of cooler weather, which is generally associated with increased virulence and a greater mortality. The reports from the outlying cities and provinces of the Bombay Presidency are less favourable. Outside the city of Bombay the epidemic appears to be spreading, and for several weeks past there has been a gradual increase in the death-rate. In the Mysore State the plague is steadily advancing, particularly along the lines of communication; which supports the view that human intercourse is the chief means of conveying infection from one centre to another. North of Bombay the plague is almost entirely absent. The Punjab is unaffected, and in Calcutta no case has recently occurred.

As the Indian Government has appointed a Special Commission to inquire into the medical, economic, and social problems raised

by the plague in the Bengal Presidency, Dr. Koch's recently published reports now derive additional interest. With the exception of the brief introduction, the publication in question consists of reports sent from time to time by Dr. Koch to the Minister of Agriculture at Cape Town and to the Minister of the Interior at Berlin. As the result of his investigations in India, Dr. Koch concludes that human beings alone are the means of propagating the disease; and in the absence of human inter-communication, favours the hypothesis that the infection is spread by rats. Dr. Koch speaks very highly of Dr. Haffkine's system of prophylactic inoculation. He considers that the results attained at Damaon fully establish its prophylactic value. The difference in mortality between the inoculated and the non-inoculated is encouraging, though the protection afforded is not absolute.

Whatever may be the value of Dr. Koch's report upon the plague in India, his reputation, as a writer in the *Saturday Review* recently pointed out, has not been enhanced by his published statements regarding the black-water fever of tropical Africa. Few living men have enjoyed more world-wide renown than Dr. Robert Koch; his work on the bacillus of tuberculosis having early made for him a high reputation as an investigator. Unhappily, some of Dr. Koch's later achievements have not fulfilled the promise of his early successes. Experts have not accepted as valid his alleged discovery of the bacillus of cholera; and his announcement that he had discovered a safe and reliable remedy for tuberculosis has not been verified after eight years of trial. Black-water fever is confessedly one of the most deadly and most obscure of the diseases from which Europeans suffer in tropical Africa. For some time the disease was supposed to be caused by malarial parasites, but more recent investigations have proved that the blood of patients suffering from black-water fever is frequently free from

these organisms. Sambon claimed that the fever is due to the parasite that causes Texas fever in cattle. In opposition to both of these organic theories, Tomaselli attributed the fever to quinine poisoning; but his theory has been fully investigated by Küchel, Stendel, and others, and declared to be untenable, as black-water fever attacks people who have never taken quinine, and quinine, when properly administered, checks the disease and even cures it. Dr. Koch, having observed some sixteen cases in the hospital at Dar-es-Salaam, where he found that the administration of a large dose of quinine was occasionally followed by a high temperature in patients suffering from the disease, has put forward again Tomaselli's discredited theory. As there is always a difficulty in persuading irritable fever-stricken patients to take quinine regularly and in proper doses, Dr. Koch's report will probably do much harm. In a recent number of the *British Medical Journal*, Dr. R. Moffatt, of Uganda, writes that quinine is the only remedy that will cure black-water fever, but that some of his patients now refuse to take it in consequence of Dr. Koch's report.

Dr. Koch is, however, entitled to the gratitude of all nations for the means he has placed at our disposal for the detection of tubercle in animals. In the *Nineteenth Century* for October, Sir Herbert Maxwell, Bart., M.P., Chairman of the Royal Commission on Tuberculosis, in an article entitled "Tuberculosis in Man and Beast," calls attention to the great value of Dr. Koch's tuberculine test. The large number of tuberculous cows in this country (77 per cent. have been found to be tuberculous on one dairy farm by means of Koch's test) probably accounts, to a great extent, for the relatively high death rate among children in Great Britain and Ireland. It has been shown that deaths from tuberculous diseases, at all ages, has steadily fallen from 3,483 per

1,000,000 during 1851-60 to 2,112 per 1,000,000 during 1891-95, a decrease of 39.1 per cent., but the death rate from the same disease in children up to five years of age, when their chief article of diet is cow's milk, has only decreased 3 per cent. As tubercular disease in children is usually due to infection from the alimentary canal, the feasibility of prevention is obvious. In other civilised countries, notably in Denmark, the tuberculine test has now been used for several years, with the result that the herds have become relatively free from tubercle. It is humiliating to have to admit that Great Britain is behind other countries in this respect.

The popular support given to the crusade against tuberculosis bids fair to afford tangible and far-reaching results of a most beneficial character. All honour to members of the profession and others who are so strenuously supporting the National Association for the Prevention of Consumption! The value of concerted action on scientific lines has been well demonstrated, both in America and in France. In the latter country the Congrès pour l'Étude de la Tuberculose, which was established in Paris in 1888, under the presidency of the distinguished investigator, Monsieur Cheval, has attained most practical results in Paris, and throughout France generally. The public mind has been largely educated regarding the preventable nature of the disease; and preventive measures which, ten years ago, were considered out of the question, are now not only freely discussed by city and municipal administrators, but have in great part been adopted. In America, where prevention has been systematised more fully than elsewhere, "notification" is now on its trial, and in many of the large cities various more or less stringent measures are enforced. Surely the time is ripe for advanced legislative action in this country. The profession is unanimous upon the requirements demanding attention at the hands of the

Government, and the excellent and definite results being obtained in other countries remove the measures proposed from the realm of experimentation to that of exact knowledge.

Dr. J. Niven, Medical Officer of Health for Manchester, read a valuable paper, dealing with the problem of tuberculous meat and milk, before the Sanitary Congress, held in Birmingham last month. This question has advanced from the position of preliminary inquiry to that of practical demonstration, and we are now justified in putting aside heredity as the only important factor in the propagation of the disease. Muscle substance, however, as Dr. Niven points out, is rarely capable of causing infection, the tubercle being generally found in the lymphatic glands embedded in the tuberculous meat. The ordinary process of cooking does not suffice to ensure the destruction of the infective agent in the deep-seated glands. The Royal Commission on Tuberculosis decided that tuberculous milk is a much more dangerous source of infection than tuberculous meat; but the serious nature of the danger from both sources is generally under-rated. That an enormous quantity of infectious milk is consumed in large cities is shown by Dr. Niven's statement that the milk from five out of nineteen cows, taken at random in Manchester and sent to Professor Delapine for examination, contained tubercle bacillus. In ninety-three samples of milk, selected at random at the Manchester railway stations, no fewer than seventeen contained the tubercle bacillus.

Sir William Broadbent, and Mr. Malcolm Morris have been giving excellent advice at York upon the question of sanatoria for consumptives. In addressing a meeting called by the Lord Mayor of York to consider a proposal to establish a local sanatorium for consumptives. Sir William again called attention to the fact

that in the treatment of consumption fresh air is the chief remedial agent to be relied upon; though he erred somewhat in stating that "It was not particular air that is required for the cure of consumption," but "simply air." To maintain that the air of a damp and foggy country, let it be never so fresh and free from impurities, is as curative as the dry air of a cloudless, rainless country, purified and warmed by the direct rays of a southern sun; is, assuming other conditions as being equal, certainly misleading. Fresh air, and plenty of it, will undoubtedly cure many cases of consumption even in this country; but the patient's chance of recovery will certainly be much greater if he is in a position to spend his winters on the Riviera, in Morocco, Algiers, Tunis, or Egypt, on the uplands of South Africa, or in the arid parts of Australia or America—any locality where the atmosphere is pure, reasonably warm, free from moisture, and where, day after day, moderate exercise may be taken under a cloudless sky.

The gratifying results obtained by the fresh air treatment at Edinburgh proves the great value of the open air system; but it does not prove that the same system under more favourable climatic conditions, would not give better results. Mr. Malcolm Morris's remarks at York were more to the point. What is wanted is to encourage people to believe that consumption is curable; and to teach them how it can be prevented from spreading. To the argument that the English climate is not so well suited for the open-air treatment as the climate of many other countries, Mr Morris very properly replies that the classes the crusade against consumption will benefit most are those who are incapable of taking care of themselves, chiefly the extreme poor, who cannot afford to go abroad. Include tuberculosis in the list of diseases to be notified to the medical officer of health; properly inspect our food supplies; provide special hospitals for tuberculous patients,

as now provided for those suffering from scarlatina and diphtheria; rigorously enforce by law the disinfection of all rooms occupied by tuberculous patients; educate the masses, encourage cleanliness in the homes of the poor, hasten the abolition of horse traction and largely increase the water supply in our great cities, and tuberculosis will soon cease to be the prolific cause of death it is at present.

The veteran German scientist and great pathologist, Professor Rudolf Virchow, delivered the Huxley Lecture, with which the winter session of the Charing Cross Hospital Medical School was inaugurated last month. Professor Virchow reviewed the latest developments of pathological knowledge and their influence on medicine and surgery; referring incidentally to the question of heredity, the phenomena of parasitism and infection, antiseptic surgery, and artificial immunisation. The following passage is indicative of the general tone of Professor Virchow's address:—

"The second of Huxley's three famous papers, that on the relationship of man and the animals next beneath him, limned in exemplary fashion the parallelism in the earliest development of all animal beings; but, beyond this, it stepped boldly across the border line which tradition and dogma had drawn between man and beast. Huxley had no hesitation in filling the gaps which Darwin had left in his argument, and in explaining that in substance and structure man and the lower animals are one. Whatever opinion we may hold as to the origin of mankind, the conviction as to the fundamental correspondence of human organisation with that of animals is at present universally accepted."

In the course of his lecture Professor Virchow found occasion to refer, in eloquent and eulogistic terms, to Lord Lister, whom he characterised as one of the greatest benefactors of the human race, and he was unsparing in his tribute of praise to Huxley, Hunter, and Jenner. Professor Virchow is not

only a distinguished scientist, but he is also a politician of considerable repute—not an orator in the popular sense of the term, but a clear, logical and incisive speaker, with a large reserve of quiet irony. Opposed to violent revolutionary measures, he has always advocated a peaceful and gradual social evolution. Since his entry into the Prussian Chamber in 1862, he has warmly espoused the cause of progress, and as an advocate of Parliamentary *régime* he frequently opposed Prince Bismarck. The great authority on cellular pathology naturally did not fail to touch upon his favourite theme, more especially as the subject was imposed upon him by the purpose of his lecture. Professor Virchow delivered his address in English, showing a thorough mastery of our tongue, and, even in the most restricted sense of the term, of our idiom. His motto for the medical school, "The organism is not an individual but a social mechanism," calls attention to one fact, however, which has not been generally noticed—namely, that in principle Virchow's teachings have always been opposed to Huxley's ardent advocacy of individualism. Huxley and Virchow approach most scientific and political problems from a widely different point of view.

Sir James Crichton Browne has been somewhat unjustly censured by his critics on account of certain of his remarks on poisons and poisoning in his inaugural address before the Pharmaceutical Society. It has been claimed that the lecturer, by taking the general public into his confidence, went out of his way to teach murderers and suicides their business, especially with regard to the case with which criminals may encompass the death of those whom they may have designs upon, by scientific methods that render the detection of the crime impossible, when, as a matter of fact, his critics have been infinitely the more culpable. Homicides and suicides do not, as a rule, devote much time to the perusal of

lectures delivered before scientific bodies, and if Sir James's critics had, in their wisdom, considerably refrained from giving such widespread publicity to the remarks complained of, the public would have less cause to fear the early formation of a school of microbe connoisseurs with homicidal tendencies.

The conscientious objector will hardly be satisfied with Dr. Barry's report on the small-pox epidemic in Sheffield, which shows that the vaccinated children, compared with the unvaccinated, enjoy a twenty-fold immunity from smallpox, and a four-hundred-and-eighty-fold security from death by that disease. The relative safety of vaccinated children living in houses actually invaded by small pox, as compared with the un-vaccinated, is so striking that we reproduce Dr Barry's figures—

	per 1,000
The attack-rate of the vaccinated.....	78
The attack-rate of the unvaccinated ...	869
The death-rate of the vaccinated	1
The death-rate of the unvaccinated ...	381

Similar proof of comparative immunity is demonstrated throughout the report. Eliminating children under ten years of age, and taking only the population above that age, Dr. Barry found the comparison between the vaccinated and the un-vaccinated is as follows:—

	per 1,000
The attack-rate in persons twice vaccinated ...	3
The attack-rate in persons once vaccinated ...	19
The attack-rate in persons not vaccinated ...	94
The death-rate in persons twice vaccinated ...	0·08
The death-rate in persons once vaccinated ...	1
The death-rate in persons not vaccinated ...	51

Unfortunately, the conclusive evidence afforded by such statistical returns has but little weight with "conscientious objectors," and they will in all probability continue to deny the efficacy of vaccination, notwithstanding proofs so significant.

The Paris correspondent of the *Daily Mail* mentions a most curious case of somnambulism, which has recently been reported from Alfortville. M. Antoine Clichy, a gentleman possessed of considerable property, found that a package containing bonds, value £2,400, had been stolen from his bedroom. He informed the police, who were unable to find any trace of the entrance of the thief. Three days later M. Clichy was obliged to take his wife, who was suffering from nervous prostration and was greatly agitated and excited by her husband's loss, to the Salpêtrière Hospital. The physician in attendance hypnotised Mme. Clichy, and drew from her the extraordinary confession that she herself had stolen the bonds, which she said she had buried under a cherry tree in their own garden. M. Clichy immediately went home, and discovered the bonds intact in the place designated. He returned to the hospital, and found his wife totally unconscious of the revelation she had made. She is now much better, and is absolutely unaware of the identity of the thief.

It is rumoured that the Government propose to appoint a committee to inquire into the "massage" scandal as soon as Parliament meets. As the facts are notorious, and require no ventilation, and as they have for years been the subject of private representations to Scotland Yard by the medical authorities, the need of a committee of inquiry is hardly apparent. What is urgently wanted is a short Bill as soon as the House sits, making it illegal to conduct any "massage" establishment without a license. If the authorities have the wisdom to extend the measure to all private homes for medical or quasi-medical purposes, so much the better.

Although the birth-rate began to decline in France earlier than in any of the other great countries of Europe, the figures of the Registrar-General show that the same tendency is

now strongly marked in England, and in nearly every other European country. It is quite conceivable that a couple of generations hence the birth rate in France may no longer be the lowest in Europe. As a matter of fact, the rapid growth in European populations is a phenomenon confined almost entirely to the last 150 years. During some of the grandest periods of English history the population of Great Britain remained almost stationary.

Syphilitic lesions of the stomach have been but seldom described. Possibly, as M. Dieulafoy has recently asserted, they are not so uncommon as is supposed, for when they come under clinical observation it is usually as ulcers of the stomach and the symptoms do not differ from those of ordinary ulcer. Gummata have been found at necropsies, but as a rule they produce symptoms during life only when they ulcerate. A case such as the following, published in *La France Médicale*, July 1, 1898, by Dr. Dubuc, is very exceptional. In 1880 and 1881 he treated a man for primary and secondary syphilis, and in 1884 for a tubercular syphilide on the forearm. In 1891 he detected in the epigastric region a large indurated plaque of the size of the palm of the hand, with a projection having the volume of a pigeon's egg. It was situated behind the abdominal wall and no doubt in the wall of the stomach. It was separated from the liver by a narrow zone, and was elevated by the pulsations of the aorta. The patient had wasted, digestion was slow and difficult, and there was pain in the affected region. Mercury and iodide of potassium were given; the plaque appreciably diminished in a week, and was found to have entirely disappeared when the patient was seen four months afterwards. M. Dieulafoy's advice to inquire for a syphilitic history in all cases of gastric ulcer, and to treat accordingly, is sound.—*Lancet*.

EUTHANASIA.

The Reverend Charles W. Wendte, in the *New York Journal*, has had the moral courage to write in favour of euthanasia. He says:—"Although I strongly advocate the destruction of certain people by humane methods, I am not willing that my position in this matter should be misunderstood. All pioneers of thought have suffered misrepresentation, and I desire, as much for the benefit which may result to the world as for the defence of my own reputation as a humane man, to be thoroughly comprehended.

"A few years ago an engineer of eminence in France, afflicted with a terrible inherited disease, of which he had seen his own father perish under agonising tortures, took his own life. In his will he explained the reason for his violent deed, and left to the French Government a large bequest for the establishment of a commission on euthanasia. The French Government, influenced, it was claimed, by clerical counsels, declined to accept the trust. In this, I believe, it did wrong. Though I appreciate the difficulties attending the matter, and what special dangers to society it may seem to carry with it, I yet believe that the time is rapidly approaching when the painless destruction of incurables will be considered eminently wise, humane, and Christian.

"As in the case of the French suicide, my theory meets with the greatest opposition in clerical circles. In the first place, I am told that He who gives life should take it. Now, I hold that in that case all capital punishment, all forcible resistance to personal violence which may cause death, all war, either offensive or defensive, is wicked and cannot be justified. The murderer should go free, the assassin unhanged, and the greatest generals, in place of being lauded as patriots, should be condemned as malefactors. It is plain, therefore, that this doctrine is untenable. To go further, look at the thousands of diseased, suffering, torturing human beings who crawl on this fair earth—the offspring of human

ignorance, brutality, guilt, and shame. Surely, if justice and humanity were to decide the matter, such unfortunate beings would never be allowed to come into existence at all.

"But we ought to go a step further. It ought to be a universal law throughout Christendom that the child-bearing of idiots, criminals, the insane, and all incurably-diseased persons should be prevented. How? By making it necessary that the physicians certificate should precede the issuance of the marriage license. Go to the children's hospital and see the poor little innocents, malformed, racked and tortured, from no fault of their own. Afflicted with terrible, wasting diseases, without the possibility of permanent restoration, death in many cases is only a question of weeks and months. Why insist on continuing the tortures so needless, so undeserved? Do my antagonists think that God loves to behold the agonies of infants.

"Another thing which my critical clerics assert is that God sends pain to discipline and purify us, and we ought not to resist His will. In that case the discoverers of ether and chloroform were guilty of great impiety, and the monument to their memory in Boston should be pulled down.

"Now I argue, as a general thing, that pain—excessive pain, I mean—does not purify the spirit of man. On the contrary, it blunts, hardens, and brutalises it. Of course there are noble exceptions which go to prove this rule. By our present methods we drive men to suicide by our inhumanity toward them.

"Now, in order to put a check to such happenings, to put behind us all sickly, false sentimentality in the handling of cases such as I have cited, I suggest that there should be formed a properly constituted tribunal, acting only when duly called upon by suffering humanity, and then under every necessary safeguard and restraint. Let this jury consist of a number of medical men, representatives of the Government, and any others

who might advantageously serve. To this tribunal have submitted any petition for examination or release which might be made by the incurably diseased, and indorsed by their families. Then, if they were found incapable of recovery, and sure to endure needless and great agony, the tribunal shall be empowered to gently, painlessly, and humanely put them out of suffering, and give them a release into the better world. . . . The surgeon must give pain to effect a cure. So humankind, which under God, gives life, may, in the Divine Spirit of justice and mercy, take it back again."

DIPHTHERIA.

The question of the value of injections of antitoxic serum in the treatment of diphtheria is, at the present time, receiving a considerable amount of attention in the German medical Press. As pointed out in an article reviewed in the last number of this journal, the diphtheria bacillus, or an organism undistinguishable from it even by its discoverer, Loeffler, is found in not only many of the pathological conditions never in any way connected with diphtheria, but even in the throats of normal, healthy individuals; while in some cases that are clinically diphtheria, the bacillus is absent. Recently it has largely become the fashion to diagnose the disease practically by the bacteriological test alone, a practice that appears to be both unscientific and unsatisfactory, for both of the reasons above stated. It can hardly be doubted that at present many cases are thus called diphtheria that in former days would have passed as tonsillitis, or some such malady; and that, on the other hand, cases of diphtheria in its original sense of infective membranous sore throat are excluded on bacteriological grounds. It thus becomes apparent that a comparison of statistics of former years, when the disease was diagnosed clinically, with those of recent times must be entirely fallacious. That statistics do support the deductions in favour of the serum

treatment is shown by Kövösy in an article in the *Therapeutische Monatshefte* for September, in which he replies to a previous paper by Kassowitz in the July number of the same periodical; while the fallacies of the statistical method are set forth by Schauz in a paper preceding that containing Kövösy's figures. As it can hardly be denied that in many cases of diphtheria great improvement does appear to follow the injection of antitoxic serum, the majority of medical men will probably hesitate to endorse the view of Kassowitz that belief in any remedial action of antitoxin is hard to reconcile with actual facts.*

Since the bacteriology of diphtheria appears to lead to such widely diverse opinions, it may be well to consider what are the scientific conclusions warranted by the facts. Diphtheria was originally a clinical group of cases presenting certain well-marked characteristics, and in a certain proportion of these, say 85 per cent., Loeffler's bacillus was found; in the remainder it was absent. It was also proved that the diphtheria bacillus was capable of giving rise to diphtheritic symptoms in animals; that its toxins could produce paralysis; and that, by means of small doses of these, immunity could be conferred. At the same time, it was found that the bacillus could exist within the human body without causing any evil symptoms. Thus what appears clinically to be diphtheria can be produced by the action of more than one organism. Besides the mere presence of Loeffler's bacillus, other factors, or so-called "pre-disposing causes," are necessary in order that the disease may be produced. In this way we can understand the influence, for example, of defective drainage and of foul gases in the production of the disease; also the peculiar liability of some individuals to contract it, owing to chronic enlargement of the tonsils, or similar abnormal condition.

* See report by Dr. Gordon Morrill, p. 26, No. 1, of this journal.

THE CHRISTIAN SCIENTIST FRAUD.

The scandalous inadequacy of the Medical Acts to protect the public against unskilled and irregular practice has again been painfully emphasised by the facts revealed at the inquests lately held on the bodies of Major Lester and Mr. Harold Frederic, the latest victims of the Christian Scientist.

Although, as the law stands, no medical man is permitted to employ an unqualified assistant to visit patients or attend midwifery cases, this same unqualified man and others infinitely more dangerous, such as the Christian Science frauds, may treat patients on their own account so long as they do not arrogate to themselves medical titles.

It might reasonably be expected that even the most ignorant and unthinking amongst us would view with suspicion the pretensions of charlatans, possessed of no scientific training, to cure by means of some secret remedy or simple formula all diseases to which mankind is subject. Unhappily, the reverse is the case. Enormous fortunes are made out of pills and patent medicines (which derive a quasi-authoritative sanction from the Government stamp attached to the wrapper), and almost every year witnesses some fresh imposture patronised by the public; some "elixir of life," prepared and sold by a public company, managed by a board of eminent'y respectable directors; a so-called "electric belt," claiming to possess marvellous curative properties; an infallible "cancer cure," which analysis shows to consist of distilled water; or hypnotic suggestion in some of its various forms of "healing by faith." Whatever it is, no matter how impudent the pretensions put forward by its exponents, the boundless credulity of the public assures a lucrative, if only a temporary, success.

This is especially noticeable when the cunning of the charlatan calls to his aid the

religious feeling so deeply implanted in the minds of the English-speaking peoples. The latest and most brazen example of this combination of piety and plunder is the so-called "Christian Science" system of healing, which, in common with similar frauds, so conspicuously advertises the imperative need of restrictive legislation. It is not the poor and ignorant classes only that require protection, for, strangely enough, it is chiefly the wealthier—and presumably educated—classes who allow themselves to be victimised by these pestilent cheats. Were we only concerned with the imaginary complaints, born of *ennui* and lack of occupation, we might consider such self-made victims sufficiently punished in pocket; but unfortunately the evil is of a much graver character, as the two deaths referred to above illustrate. But for the fatal interference of the Christian Scientists, both Major Lester and Mr. Harold Frederic would, in all probability, still be with us, doing their good work—the one in the service of his country, and the other delighting us with the fascinating work of his clever pen. In both cases the issues of life and death depended on constant and skilled medical treatment, which, at the bidding of these blasphemous impostors, was suspended for a sufficient length of time to render its tardy resumption unavailing. And herein lies the peril of permitting the continuance of such public dangers. Two valuable lives have been needlessly sacrificed, and it will be a lasting disgrace to our legislature if prompt measures be not taken to prevent the possibility of such sad fatalities in future.

The dead cannot be restored to life, but should the facts exposed by the evidence given before the coroner result in an early amendment of the Medical Acts so as to bring such enemies of the public health as the Christian Scientists within the purview of the law, then these two unfortunate gentlemen will not have died in vain.

LEADING ARTICLES.

LANCET, September 24 (p. 799).

Dissecting Aneurysm.

Dr. James B. Coleman relates this case. A house painter, aged sixty-five, was admitted to hospital complaining of severe pain in the back and loss of power in the legs. That morning, whilst at work, he was suddenly seized with a violent pain in the lower part of the back and in the left hip, which shot up into his chest and down into his left thigh, and which was so intense that he "bellowed with agony." Within a quarter of an hour his lower extremities were completely paralysed, and his left leg was anæsthetic. He was a well-nourished but rather anæmic grey-haired old man. He still suffered from severe pain in the back and vomited everything he ate or drank. His heart was hypertrophied, his arteries were atheromatous and his pulse was of high tension. Although he was carefully examined for aneurysm no signs of it could be detected. There was a "lead-line" on the gums. The urine contained 0.2 per cent. albumen and a few hyaline and granular casts. The knee jerks and plantar reflexes were absent. The pain in the back ceased after twelve hours, and he became much better and could move his legs freely. On the following morning he was able to walk a few steps and felt almost well. The diagnosis of plumbism and interstitial nephritis was made. The paralysis was supposed to be due to spinal meningeal hemorrhage. He died suddenly in the afternoon, fifty-two hours after the onset.

A necropsy was made. The right pleural cavity was filled with blood, the left ventricle was hypertrophied. The arch and upper part of the descending aorta were distended, forming a tumour-like mass from which blood had escaped by a small rent into the pleura. The aorta was atheromatous, and a dissecting aneurysm extended from the arch to the left

femoral artery. There was no spinal hemorrhage. The lumbar and right renal arteries were cut across and thrombosed. The kidneys were cirrhotic—the right was engorged and universal hemorrhagic infarction was present.

The necropsy, therefore, completely accounted for the symptoms: the intense pain was due to rupture and separation of the aortic coats; the paraplegia to rupture and thrombosis of the lumbar arteries; the sudden death to rupture of the aneurysm into the pleura. It was remarkable that the urine contained no blood and was not diminished, for the function of the right kidney must have been arrested.

Dissecting aneurysm is practically confined to the aorta and its large branches. Other cases have been recorded in which a remarkable series of symptoms have occurred, due to arrest of vascular supply to brain, cord, or kidneys—such as apoplexy, hemiplegia, paraplegia, anuria. The diagnosis is therefore always difficult and uncertain.

THE LANCET, September 24.

Gastric Tetany.

Dr. E. F. Trevelyan publishes three cases and exhaustively discusses the subject.

A woman aged 45 was admitted to hospital suffering from vomiting and loss of flesh. She had been much troubled with indigestion, and a month before admission began to suffer from a dragging pain in the gastric region, worse after food. A week later she vomited almost everything she ate, and had to restrict herself to liquids. During the week previous to admission she had cramp in the legs after excessive vomiting. The patient was much wasted, the tongue was coated and the bowels were constipated. There was a marked prominence in the umbilical region obviously due to dilated stomach. The lesser curvature was visible above the umbilicus and the greater $1\frac{1}{2}$ in. below it. Peristalsis could be seen, the wave passing from left to right. It was thought that a tumour could

be felt over the right extremity of the dilated stomach. The urine contained a trace of albumin. Copious vomiting appeared on the third evening, and persisted during the night. The next morning tetany supervened without previous tingling of the extremities. There were painful tonic spasms of the hands and arms, the fingers and thumbs assuming the position described as the "obstetric hand," and the wrist and elbows being flexed. The feet were also involved, and she lay propped up in bed with flexed knees. The muscles of the jaw were somewhat rigid. The patient was much exhausted; the face was dusky, the lips were blue, and the pulse was small. The temperature was $94^{\circ}6'$. The stomach was emptied, and washed out with saline solution. A nutrient enema was given, and hot saline enemata every two hours were ordered. She improved temporarily, but died in the afternoon. Death was preceded by more generalised spasm.

The necropsy showed the stomach enormously dilated, the greater curvature extending to the pelvis; the duodenum almost completely obstructed by a carcinomatous growth, the kidneys small and cirrhotic.

Dyspeptic symptoms have usually been noted for many years preceding gastric tetany, because the most frequent cause of the gastrectasis is cicatrisation of an ulcer. The most satisfactory theory of gastric tetany is that it is due to auto-intoxication from poisons generated by decomposition of the stagnant contents of the dilated stomach. A poison has been separated which produced convulsions in animals. Albuminuria and renal disease, noted in several cases, can be explained also by injury of the kidneys in the excretion of these poisons.

BRITISH MEDICAL JOURNAL, Oct. 1.

A Case of Protracted Sleep extending over Fifty Days.

Dr. Markham Skerritt and Dr. James Stewart publish the following extraordinary case. A boy, aged seventeen, engaged for a

year in severe study without allowing himself sufficient time for sleep whilst preparing for examination for assistant clerkship in the Royal Navy, which he obtained by competition in November, 1897. During the six weeks which followed he complained of feeling tired after very moderate exertion. On January 16, 1898, he was drowsy; on the following day he fell asleep on a railway journey as soon as the train started. After this it was impossible to keep him awake; he would fall asleep while he was on his feet. His pupils were much contracted and little affected by light. There was nothing suggestive of catalepsy. The pulse was slow and weak, the temperature normal, and he lay in a placid sleep. When roused to take nourishment he would reply to questions very much like a person talking in his sleep; he would frequently drop off to sleep while putting the cup to his lips. When the calls of nature occurred there was an obvious desire to respond to them; but he would frequently drop off to sleep before he could be assisted, and the inclination would disappear. Gradually this partial response ceased. Another troublesome symptom was sickness, principally after breakfast. He remained in this condition till the middle of March, when he began, while half-awake and half-asleep, to talk as in a dream, sometimes saying ridiculous things.

His weight, which had been gradually decreasing, began now to return to normal. There was no impairment of mental faculties; his memory was quite clear to events prior to his journey on January 17, and subsequent to the beginning of April; of the intervening period he had no recollection. He was unable to read for any length of time, or to watch a game of tennis, without eye fatigue. There was no evidence of organic disease, nor did he complain of headache. He completely regained his strength and is now serving as a clerk on a battleship.

There are only eighteen other well-authenticated cases of such protracted sleep; of

these only eight recovered completely; four died in sleep.

The writers make no attempt to explain this extraordinary case, but it seems clear that the strain of preparing for the examination must have been concerned in its production.

THE PRACTITIONER.

The Medicinal Treatment of Tuberculosis.

Dr. Hector Mackenzie's subject is a hackneyed one; he has no new treatment to advocate. But his article is precise and rational—a combination as valuable as it is rare in therapeutical literature. He has said almost all that is worth saying on the subject, and what is a still better he has said no more.

When a tuberculous patient first seeks advice the appetite is frequently poor. A mixture containing 15 grains of bicarbonate of soda and 3 minims of dilute hydrocyanic acid to an ounce of compound infusion of gentian is largely prescribed at Brompton Hospital. A simple mixture of this kind often does much to restore the appetite and improve digestion. The bowels are often constipated; aloes and cascara sagrada are the most useful remedies, and pills containing one or other in combination with nuxvomica and belladonna may be taken at bedtime. If the bowels are loose, bismuth and opium may be ordered.

Cod-liver oil improves the condition of the blood, promotes nutrition, and metabolism; its action in tuberculosis is probably indirect. Dr. C. J. B. Williams concluded that the average duration of life in phthisis—two years—was prolonged to eight by cod-liver oil. Why is cod-liver oil therapeutically superior to other fats? Many answers have been given. The researches of Heyerdahl seem to show that it has a more complex composition than was supposed, and that it contains two very unstable glycerides—therapin and

jecolein—each to the extent of 20 per cent. Its composition is therefore *sui generis*. At Brompton it is usually given in doses of one to two teaspoonfuls twice a day, larger doses are seldom given. Jacoud was of the opinion that the best results were obtained by the administration of doses of from two to three tablespoonfuls three times a day, but such large doses are not necessary or beneficial. Malt extracts have the objection that they are so dilute in cod-liver oil that a tablespoonful is probably equivalent to a teaspoonful of cod-liver oil; they cannot therefore be regarded as satisfactory substitutes.

Creosote has not a specific action, but it is valuable. The purest beech creosote should be given in capsules after food. The dose may be increased from 1 to 5 minims three times a day up to 10 to 15 minims. After the appetite returns, cough and expectoration diminish, fever abates, night sweats cease, strength returns, and nutrition improves. Guaiacol, which is the principal constituent of creosote, has no other advantage except the very important one that it is more readily borne by the stomach.

Arsenic in the form of Fowler's solution, 2 to 3 minims after meals, acts as a tonic and enhances the action of cod-liver oil. The arsenical waters of Mont Doré have long been held in high repute.

Antipyretics appear to be without benefit. When profuse perspirations occur the night-dress should be changed and the patient should be rubbed down with a dry towel. Oxide of zinc, 5 grains in pill, is the most satisfactory drug; $\frac{1}{100}$ gr. of atropine, or fifteen minims of the tincture of belladonna, or $\frac{1}{20}$ gr. of strychnine have been found useful. Hæmoptysis tends to subside of its own accord. A hypodermic of morphia (gr. $\frac{1}{4}$) will generally fulfil all the indications.

The treatment of cough must be guided by the condition on which it depends. If there is active secretion from the bronchi or from the wall of cavities, or if lung tissue is breaking down, expectoration is a necessity. In

such cases opium should be avoided. Cough mixtures are apt to spoil the appetite; remedies should be as simple as possible. Lozenges of gum acacia and liquorice are much used at Brompton Hospital. Dry inhalations are very useful where the cough depends on an irritable condition of the mucous membrane. Twenty drops of a saturated alcoholic solution of a mixture consisting of equal parts of cresote or guaiacol and spirit of chloroform may be inhaled.

THE MEDICAL CHRONICLE, September.

**Fracture of the Atlas and Axis, with
Crushing of the Spinal Cord: Life
Prolonged for Three and a Half Hours
by Artificial Respiration.**

By J. W. SMITH, F.R.C.S., M.C.,
and

J. GRAY CLEGG, M.D., B.S., F.R.C.S.

A cab-driver, aged forty-seven, was admitted to the Manchester Royal Infirmary. Whilst drunk, he had fallen from his box four minutes previously. He was unconscious. His face was cyanosed. The only external injury was a scalp wound. There was no sign of respiration, and the radial pulse was absent. The heart was beating feebly. Artificial respiration was performed by Sylvester's method; hot sponges were applied over the chest; and 40 minims of ether injected subcutaneously. After ten minutes the cyanosis of the face disappeared, the corneal reflex became marked, and the pupils moderately contracted. The radial pulse-beat was now full and strong, though somewhat slow. The artificial respiration was stopped, but there was no attempt at natural respiration. The face rapidly became cyanosed again, the pulse began to fail, and the patient to lapse into his former condition. Artificial respiration was continued, except at momentary intervals. He recovered consciousness and could mutter a few words. Motion and sensation in the face were normal, whilst they

were absent below the neck. The knee-jerk could not be obtained. If artificial respiration was stopped for a short time an attempt at respiration was made, which consisted only of a spasmodic depression of the lower jaw and angle of the mouth, dilatation of the nares, and protusion of the tongue. A much greater range of movement than normal existed between the head and neck; on gently moving the head from side to side crepitus was felt. A hard prominence was felt pressing forward the soft palate and almost obstructing the entrance to the pharynx. It was apparent that this was the body of the axis displaced forwards and downwards; on gently extending the head on the neck the prominence to some extent disappeared. After two and a half hours the general condition became worse, the thorax gradually became rigid, making artificial respiration more and more difficult to carry out. A constantly decreasing quantity of air thus entered the lungs until, three and a half hours after admission, compression of the chest wall became impossible and death occurred. During the last half-hour some œdema of the limbs was observed, the tongue was dry and swollen, and the patient lapsed into unconsciousness. The corneal reflex gradually disappeared, and was absent for some minutes before the pupils finally dilated. The heart gave an occasional beat for some minutes after the pupils had dilated and artificial respiration had been abandoned. The rectal temperature half an hour before death was below 95°.

The necropsy showed the odontoid process, and upper third of the body of the axis, separated from the remainder of the bone, the atlas fractured in three places, and the cord almost completely divided.

The remarkable point in this case is that, though the cord was almost completely divided below the medulla, life was prolonged for some hours by artificial respiration. The writers have been unable to find any similar case among recorded injuries of the

upper end of the spinal column. They do not mention a very instructive parallel fact, not generally known, that in some cases of cerebral disease the function of respiration ceases for some hours before that of circulation. In a paper read at the last International Medical Congress Sir Dyce Duckworth showed this. In one of his patients—a case of cerebral abscess—life was prolonged for $4\frac{3}{4}$ hours by artificial respiration. The explanation of all these cases is that the function of respiration is dependent on the central nervous system, whilst the cardiac is to a certain extent independent of it.

Mr. Eve has collected eleven cases of fracture of the axis besides one which came under his observation. In one only was death instantaneous, whilst complete recovery occurred in two. Paralysis supervened immediately in three cases, and after an interval in six, whilst it was altogether absent in two. He points out that paralysis is "a less frequent or, at any rate, not so immediate a symptom as in fractures or dislocations of the spine lower down. The large amount of room allowed for the cord by the posterior arch of the atlas permits a considerable displacement before it is seriously compressed." In five cases the atlas also was fractured, in one of which, recorded by McCarthy, it was broken into five pieces. There was, however, no displacement or evidence of compression of the cord.

THE SCALPEL, Oct., 1898.

The Uses of Biniodide of Mercury.

Many, no doubt, have thought that the claims put forward by Dr. Illingworth for biniodide of mercury were ridiculous. With the greatest persistency he advocated its use in an extraordinary variety of affections. In fact, as a medical writer, this seemed to be his sole object in life.

Dr. Hanbury Frere contributes a paper to the *Scalpel* which may be described as a re-

statement of Dr. Illingworth's conclusions, based on his own experience. There may be more in these views than might be supposed. Iodine and mercury are two very powerful remedies, and their field of undoubted utility is by no means confined to syphilis, and may be still wider than is known; moreover, utility in the other exanthemata would only further illustrate the parallelism of these diseases to syphilis. Any views based directly on observations deserve at least a hearing. We subjoin the most important part of Dr. Frere's paper:—

"In obstetric practice I employ an ointment of biniodide dissolved in iodide of sodium, in collapsible tubes as a lubricant, and biniodide lotion prepared from tabloids for the hands and instruments. With these precautions I do not believe there is the slightest fear of conveying infection. In infectious ophthalmia and in otorrhœa I know of nothing better than a solution of biniodide of mercury (1 in 3,000), containing gr. 3 to the ounce of zinci sulph."

"A solution of 1 in 500 I use for painting the throat in scarlet fever, and in the treatment of ringworm and alopecia areata."

"An ointment of biniodide in iodide of sodium acts well in causing the absorption of enlarged glands, and in reducing the size of the thyroid in exophthalmic goitre. I make an ointment with vaseline, with the addition of a glycerole of biniodide in iodide of sodium, and if the skin becomes red, the ointment is withheld for a day or two. I believe the addition of the iodide of sodium is of importance in rendering it far more penetrating."

"Internally I have employed the biniodide dissolved in iodide of potassium very extensively. Perhaps the most striking effect of its administration is seen in scarlet fever. In spite of what authorities may say, the biniodide of mercury does seem to shorten the duration of the illness, to procure an earlier convalescence, and to lessen in a marked degree the danger of complications and sequelæ. For the first few days, at any rate, the throat is painted with a 1 in 500 solution

of biniodide, and this I believe to be a most important element in the treatment. The biniodide is also given internally every two hours in doses of gr. $\frac{1}{32}$ or gr. $\frac{1}{16}$, either in mixture or powder. Since I knew of this treatment I have only seen one case of post scarlatinal nephritis, and that in a boy difficult to manage."

"In measles and whooping-cough where the ordinary treatment is supplemented by the administration of the biniodide of mercury in powder, the disease takes a much more favourable course."

"I have by no means exhausted the list of cases in which it is of service. I must not omit, therefore, to mention the great value of the biniodide in infantile diarrhoea which has been so ably described by Luff (*Lancet*, December 20, 1890)."

"It has been said that this drug has been recommended for too many things, yet I know of no instance in which its employment has been advocated contrary to what we should expect from our knowledge of therapeutics. It must be remembered that this salt is first of all a mercurial, and that it possesses certain advantages over other mercurials.

"The bichloride of mercury, which is still extensively used, coagulates albumen and is not sufficiently penetrating. If it is not used with the greatest caution it is dangerous as an intrauterine injection. All this is in favour of the biniodide, and if further proof were necessary of its safety I think it is to be seen in the fact that at some electrical works small doses of iodide of potassium are given to the men daily as a safeguard against mercurialism."

THE MEDICAL AGE, October 10.

The Treatment of Sprains of the Ankle.

Dr. G. H. Adams confirms the claims of the treatment of sprained ankle by what is known as the Gibney bandage in America, a method really due to Mr. Edward Cottrell,

of London. The results are certainly remarkable, for the patient to his great surprise can usually walk with comparative comfort after the application of the bandage, and in a few days is practically well.

The plan is simplicity itself. It consists in applying a tight bandage composed of adhesive plaster to the ankle and lower portion of the leg, immediately after the injury, paying no attention to rest or elevation—at least not after the first twenty-four hours.

The details of the application are as follows: Ordinary adhesive plaster is cut into strips $\frac{1}{2}$ in. wide and in two lengths—about 12 in. and 18 in. One of the longer strips is placed around the ankle, parallel to the sole of the foot, beginning in front of the big toe, carrying the strip around the ankle just above the contour of the sole, and bringing the end back across the top of the foot to about the point where the strip began. It is well to place, overlapping this initial strip, a parallel piece. In placing these strips on, care should be taken to draw them as tightly as possible, so that the bandage will fit snugly when finished. Having applied these strips, another strip should be placed at right angles to them, which makes it run parallel to the back of the leg. One of the shorter strips should be selected for this purpose. Beginning well behind and above the ankle this strip should be carried down around the sole of the foot and brought up on the other side of the leg, making, as it were, a stirrup for the foot. The same precaution of applying the strip as closely as possible should be observed. Now the strips should be applied alternately: first one around the ankle parallel to the sole, then one parallel to the back of the leg, each one overlapping the one previously applied, running in the same direction to some extent. This procedure should be kept up until the entire foot is enclosed in a boot of adhesive plaster, having the appearance of a shoe in which part of the heel has been cut away. This dressing properly applied has a very neat appearance; over it can be placed an

ordinary roller bandage, which will help the plaster to adhere. The patient should be cautioned to be careful for a day or two, when he can begin to move about rather freely. This dressing can be kept on until the pain and swelling have subsided, when it can be removed, and no further treatment is required. If the dressing becomes loose, it can be reinforced by additional strips place over the loose ones.

The following case is characteristic: A tennis player fell while playing and sprained his ankle. He was a heavy man, and the sprain was so severe that he was unable to put his foot on the ground, whilst walking on it was simply out of the question. Adhesive strips were at once applied, and after much coaxing the patient placed his injured foot on the ground tenderly; to his surprise he found that he could walk, not rapidly nor well, but that he could bear his weight on the limb and go home without assistance. He remained in the house for the rest of the day, was able to walk on the following day, and in a week was almost as well as before the accident.

THE QUARTERLY MEDICAL JOURNAL,
October.

Aneurysm of the Femoral Artery in a Child; Operation: Digital Compression of the Iliac Artery through an Abdominal Incision.

By RAYMOND JOHNSON, B.S., F.R.C.S.

Aneurysm is rare in childhood because its causes are rare. Chronic arterial disease—all important at later periods—may be practically excluded. On the other hand, embolism—of small relative importance in middle life—is the most likely cause in childhood. As to its mode of action, the simple mechanical theory is insufficient. Embolism is only likely to be followed by aneurysm if the embolus can excite arteritis; a simple embolus cannot, hence the view—supported by a good deal of clinical evidence—that the embolus must be

infective. How is it that the arrest of the embolus in the main vessel is unaccompanied by evidence of interference with the circulation through the limb, and that the aneurysm may be situated at a part of the artery where it is unlikely that an embolus would be arrested? The explanation is that when an embolus causes an aneurysm of a large artery it has been arrested not in the lumen of the main trunk, but in the mouth of a small branch. By the development of a localised arteritis at this spot an aneurysm would be produced without any manifestation of circulatory disturbance.

The following case is of interest on account of the rarity of aneurysm in childhood and the treatment adopted. A thin, pale, delicate girl, aged thirteen, was admitted to hospital for supposed hip-joint disease with suppuration. She had had rheumatic fever at the age of ten, and again two months before admission. For nine months there had been lameness and pain in the right hip. The pain increased, and for six weeks had been so severe that the child could not walk. A fortnight before admission a swelling was observed in the right groin, which had increased considerably. There was marked clubbing of the fingers. The appearances suggested hip disease, and that a large abscess had formed in front of the joint. The thigh was flexed and abducted; Scarpa's triangle was occupied by a large swelling. The skin of the part was hot, and slightly reddened. But the swelling was expansile, a thrill could be felt, and a bruit could be heard. The limb was otherwise normal. There was a loud cardiac systolic murmur, heard best in the right second intercostal space.

Two explanations presented themselves: either that the swelling was a femoral aneurysm, and that the position of the limb was the result of the painful and rapidly increasing tumour, or that an abscess from hip disease had opened up the femoral artery or one of its branches. Aspiration with a fine needle gave exit to bright blood, which sup-

ported the former view. During the next few days the overlying skin became more reddened, and the tumour became larger and harder, but almost ceased to pulsate. It was concluded that partial coagulation had occurred. On account of the diffused character of the aneurysm, it was decided not to ligature the iliac artery, but to lay open the sac and ligature the femoral artery above and below the opening into the sac. As the child could not bear much loss of blood, rather than trust to any of the ordinary methods, Mr. Johnson decided to perform laparotomy and to directly digitally compress the common iliac artery (according to the method of McBurney, of New York, who thus successfully controls hemorrhage in amputation at the hip joint). The aneurysm was laid freely open; a large quantity of fluid blood and partly black and partly pale and laminated clot were evacuated. The opening proved to be on the inner side of the femoral artery. The artery was tied above and below and divided. No hemorrhage occurred when the pressure on the iliac artery was removed. The cavity closed by granulation and the patient made a good recovery. In future Mr. Johnson is disposed to adopt this method of controlling the circulation in amputating at the hip joint, and in dealing with vascular tumours and aneurysms in the groin.

THE QUARTERLY MEDICAL JOURNAL,
October.

Xerostomia (Dry Mouth).

Dr. A. J. Hall publishes a case of this rare disease and a very complete analysis of all previously recorded cases.

A woman, aged forty-eight, after an illness supposed to be influenza, began to suffer from marked dryness of the mouth. She was by no means neurotic, and had been exposed to no shock or worry. When seen a year after the onset her general health was fairly good. She complained of the discomfort caused by the condition of her mouth, a feeling of grittiness

of the conjunctivæ, and a tendency to bleeding of the nose. She could not taste food and had constantly a "salt taste." The dorsum, sides, and tip of the tongue were quite dry and of a smooth dull red appearance, marked by shallow fissures into areas resembling a crocodile's skin. The filiform papillæ were absent, and the fungiform prominent. There was slight moisture at the base of the tongue. The gums, cheeks, and palate were dry and glazed. She had a difficulty in masticating food, which she had to dilute excessively. The salivary glands did not secrete, and were not swollen. Tears could be shed, and sweating took place occasionally. Thus the case was typical.

An analysis of the thirty-nine recorded cases shows the following facts:—Thirty-two were in females and four in males. The age (not of onset) was between 20 and 30 in three; between 30 and 40 in five; between 40 and 50 in eight; over 50 in eighteen. The mouth was affected alone in thirty-six; nose also in ten; eyes also in seven. The skin was stated to be very dry in only two. The disease lasts for the patient's lifetime. In eight cases the parotid glands were enlarged; in five this enlargement varied from time to time, which in one occurred every two or four weeks, and in another the swelling was increased and tender at the menstrual periods, when also the mouth dryness was worse. As to the etiology, six followed upon a severe mental shock, four were preceded by a slight fibrile attack (influenza?), in twenty-four the cause was unknown.

The prevailing theory is that the disease is of nervous origin. In some cases it seems to be a cessation of function comparable to what occurs in the ovary and mamma. The well-known association of the parotid glands and generative organs, not only in mumps but in diseases and injuries of the latter, may be mentioned in this connection. Associated affection of the lachrymal and salivary glands is observed in mumps very rarely and in a very rare malady characterised by chronic enlargement of all the salivary

and the lachrymal glands. Dr. Hall observes that there is no evidence to show why, in some cases, the parotid glands should be enlarged. On this point we may refer to an interesting speculation by Dr. Thomas Harris, of Manchester, in a paper on Xerostomia, published in the *American Jour. of Med. Sciences*, March, 1898. Mr. Stephen Paget has shown that parotitis often occurs in connection with injuries and diseases of the abdomen and pelvis, and that it is in some way due to reflex nervous action. Dr. Harris compares this parotitis with the enlargement present in xerostomia, and concludes that the latter is probably produced by nervous derangement, the same that causes the arrest of salivary secretion.

THE THERAPEUTIC GAZETTE, October 15.

Enemata Rashes.

From time to time cases of rashes have been published, usually erythematous, and resembling the eruption of scarlatina, but sometimes urticarial, following the administration of enemata. As they quickly pass away their recognition is of importance only because an erroneous diagnosis of scarlatina may be made.

Dr. Raymond Crawford publishes a very complete account of the subject, based on fourteen cases.

The rash invariably occurred in young patients. The eldest was a girl aged sixteen. It was not in every case associated with constipation; in two cases it followed half-pint enemata of salt and water used for thread worms. Of the remaining cases five were suffering from typhoid fever, three were cases of chlorosis, one was a case of gastric ulcer, one a case of inflammatory trouble in the region of the sigmoid, and the remaining two were in children prior to operation. There was thus a marked association with gastro-intestinal disorder, and constipation was only absent in two of the cases. However, it must be borne in mind that these are the very cases

in which, in the nature of things, enemata will most probably be used.

It is difficult to say how soon after the injection the rash appeared, as it was often not noticed until the patient was washed. It commonly originated on the buttocks. In one or two cases it appeared within three hours of the enema. In the milder cases the rash was usually scarlatinal in character and diffuse, but in more severe cases confluent; occasionally it was urticarial. There was no absolute uniformity of distribution, though the localisation was to some extent a diagnostic feature. It was symmetrical, usually most marked upon the buttocks, spreading downwards over the thighs, front and back, to the knees; in an upward direction it commonly extended as high as the angle of the scapula, and tended to be thicker over the flanks than over the abdomen. The arms, above and below the elbows, were affected, but not so constantly as the legs. Only in five was the face affected, then the distribution was general over the forehead, ears, cheeks, and on the neck, particularly along the line of the lower jaw. There was nearly always some degree of irritation, not marked in the scarlatinal, but often intense in the urticarial cases. In one or two there was no complaint throughout. The rash usually subsided in less than twenty-four hours, but in one case an urticarial rash persisted for three days. In none was the rash followed by desquamation.

In all but two cases the initial enemata were of soap and water. That the soap was not a necessary factor was proved by the fact that in one case an enema of water had been administered. There was soreness of the throat in one case, but not sufficient to suggest scarlatina. In four there was a rise of the temperature, but not above 102°.

The most reasonable of the theories which have been advanced to explain these eruptions is that it is due to absorption of some faecal substance which has been dissolved by the enema.

THE MEDICAL NEWS, Oct. 1, p. 417.

The Abuse and Dangers of Cocaine.

Dr. W. Scheppcgrell publishes a useful paper summarising the literature of this subject. Abadie reports a case of death following the injection of a 5 per cent. solution for operation on the eyelid. Consciousness was lost in ten minutes, the respiration stopped, and the face became cyanosed. The patient was partly resuscitated, but died in the evening. In a case reported by Simes, internal urethrotomy was proposed, a 20 per cent. solution was introduced into the urethra by a long-nozzled syringe, which passed about four inches. Immediately there were toxic symptoms—twitching of the face, staring eyes, dilated pupils, frothing at the mouth, congested face, laboured respiration, and finally epileptiform convulsions. The heart became irregular and slow, the entire body cyanosed. Death occurred in twenty minutes. In two other urethral cases the fatal doses were 1 grain and $\frac{1}{3}$ grain. A 4 per cent. solution applied to a blistered surface, and in a rectal case $\frac{2}{3}$ of a grain in two doses have been fatal.

Its use in dentistry has caused several deaths. A healthy woman, aged twenty-nine, died after the injection of $\frac{1}{3}$ grain for extraction, which was painless (*Zeitschrift f. Zahnheilkunde*, Sept. 25, 1890). In another case which proved fatal 4 grs. were injected into the gums (Haynes, *Med. News*, July 7, 1894). Several cases are also reported in which toxic symptoms were produced.

The application of cocaine solution to the nose and throat does not appear to have ever been fatal, but several cases of toxic effects are recorded. A 4 per cent. solution applied to the nasal cavities has produced vertigo and syncope, and even a 2 per cent. solution has caused severe symptoms. Toxic effects do not follow as readily from its use in the mouth and throat, because the absorbent power is less than that of the Schneiderian membrane. Spraying the throat for

fifteen minutes with a 2 per cent. solution produced weakness of the lower limbs, staggering and unconsciousness, lasting several hours. A 4 per cent. solution applied to the tonsil has been followed by violent toxic symptoms.

The infiltration method of anæsthesia of Schleich minimises the danger of toxic effects and should be used whenever possible.

A remote danger from the use of the drug is the development of the cocaine habit, which has now become a serious evil. It most frequently results from the use of the drug in affections of the nose and throat. The evil is as great as the morphia habit. Among the effects are rapidly-increasing marasmus, hallucinations, anorexia, insomnia.

MEDICAL NEWS, Oct. 8.

Impregnation after Castration.

Dr. F. R. Sturgis surveys the literature of this subject, ancient and modern. Aristotle ("History of Animals," Book III.) says that "A bull has begotten young if admitted to the female immediately after castration." In the *American Intelligencer*, 1838, Dr. Pue states that a castrated boar had intercourse with a number of sows, of which the first bore a litter. In the same article it is stated that Mr. Walton Hamilton, a great breeder of horses, had known several instances of impregnation after castration. Obolonsky (*Vierteljahrschrift f. Gerichtlichen Med. N. F.* Bd. 48, p. 362, 1888) castrated a dog, and found in the vesicular seminales living spermatozoa thirty-one days after the operation. Masuraca made a series of experiments of this kind, finding live spermatozoa in dogs on the sixth day and in cats on the seventh.

Turning to man, cases are recorded of men castrated for disease, whose wives became pregnant. But in Dr. Sturgis's paper there is no attempt to remove the suspicion with which such cases must be received. More importance is to be attached to the following cases. Krahmer ("Handbuch des Gericht.

Med.," 1857) records the case of a young peasant, who castrated himself with a razor and had a seminal emission twelve days afterwards. Princeteau ("Annales des Malad. des Organes Genito-Urin.," 1890) has published the case of a young man, castrated for tubercular testes, who frequently practised coition and had ejaculation of fluid containing spermatozoa. Gould and Pyle ("Anomalies and Curiosities of Medicine") state that spermatozoa have been found days and weeks after castration, but they give no authorities.

AMERICAN JOUR. OF MED. SCIENCES, Oct.

Gastric Syphilis.

Dr. Simon Flexner contributes a valuable article on this subject. The literature is very meagre; he could find only fourteen reliable cases, of which thirteen were German and one French. According to him there is no instance recorded in the English language. This is scarcely correct. In the *Brit. Med. Jour.*, 1891, II., p. 696, Dr. J. Keser has recorded the case of a young woman treated at the French Hospital, the subject of secondary syphilis who had all the symptoms of gastric ulcer. She was treated with bismuth and nitrate of silver, and fed by the rectum. But only temporary improvement took place, and the hæmatemesis continued. Various drugs were tried without success. The constitutional disease was then discovered, and the patient at once improved under specific treatment. Again, as regards French literature, he is not accurate. The subject has recently attracted the attention of clinicians. M. Dieulafoy discussed the subject at the Académie de Médecine on May 17. He concluded that gastric syphilis is not so uncommon as is supposed, and that as the symptoms differ in no way from those of simple ulcer, a history should be sought in every case. In *La France Médicale*, July 1, 1898, Dr. Dubuc has published the case of a man the subject of tertiary syphilis, in whose stomach an indurated plaque could be felt,

which diminished rapidly under mercury and iodide of potassium. As far as anatomical specimens are concerned, however, Dr. Flexner appears to be correct; German industry almost monopolises the subject. The Transactions of the Pathological Society of London do not contain a single reference to the subject. Of the fourteen cases, five were of the inherited and nine of the acquired form. The lesions found were gummata, ulcers, and cicatrices, and were usually accompanied by syphilitic disease of other viscera and sometimes by intestinal ulcers. All the acquired cases appear to have been in the tertiary stage, but some of the congenital occurred in newborn infants. Chiari paid special attention to gastric syphilis; in 243 necropsies, where syphilitic lesions were found, there were 2 cases of gastric syphilis.

Dr. Flexner records the case of a man aged fifty-two, whose illness extended over three years. He had severe vomiting following a drinking bout. The spleen was enlarged, ascites appeared, and then anasarca of the legs and scrotum. He was repeatedly tapped; $3\frac{1}{2}$ gallons of fluid were withdrawn on the first occasion. The liver was hard, but there was no increase of the area of dulness. Before death he suffered from intense abdominal pain and tympanites. The necropsy showed old adhesions between liver, stomach, spleen, and pancreas; the liver gummatous and its capsule thickened; perforating ulcer of the stomach; the spleen enlarged and its capsule cartilaginous.

AMERICAN JOURNAL OF OBSTETRICS, Sept.

The Bacteriology of Puerperal Fever.

By Prof. J. WHITRIDGE WILLIAMS.

Whenever the temperature during the puerperium reaches 101° in the Johns Hopkins Hospital, cultures are made from the uterine cavity. The patient is placed in Sims' position, the external genitals are disinfected, the cervix is seized with a forceps and brought down, its exterior and the external

os are wiped with sterile cotton; a sterilised glass tube is introduced into the uterus and passed up to the fundus, lochia are aspirated into it by a syringe, and cover slips and cultures are made. The blood also is usually examined. In 40 cases, streptococci were found in 8, staphylococci in 3, colon bacilli in 6, gonococci in 2, anærobic bacteria in 4, aerobic bacteria in 3, bacteria in cover glass but not in cultures in 4, diphtheria bacilli in 1, bacillus ærogens capsulatus in 1, typhoid bacillus in 1; the cover glass cultures and blood were sterile in 11. In several cases there was mixed infection—streptococci and colon bacilli; staphylococci and colon bacillus; typhoid bacilli, streptococci, and staphylococci. Streptococci have been found so frequently in fatal cases of puerperal fever that until very recently some have considered them the sole organism; later investigation has shown that this is not so, which the above cases bear out. Streptococci are, however, the most important etiological factor, especially in fatal forms of puerperal fever.

An advantage of bacteriological examination is that a definite diagnosis can be promptly made, and infection by the more dangerous pyogenic bacteria, when they are absent, negatived. Also in the eleven cases where no bacteria were found it enabled puerperal fever to be excluded. How great a gain this is, can only be appreciated by those who have experienced the relief of finding the uterus sterile with a temperature of 103° F. or 104° F. In many instances the pyrexia was probably due to an auto-intoxication from the intestines, indicated by rapid fall of temperature after purgation. In others it was undoubtedly due to disturbances in connection with the breasts. In a malarial case the association of puerperal fever was by this method excluded.

Dr. Williams' work has led to the discovery of puerperal infection by organisms not previously or but rarely described as causes—

bacillus ærogenes capsulatus, diphtheria bacillus, and typhoid bacillus.

AMERICAN JOURNAL OF OBSTETRICS, Sept.

Hysterical Eructations.

By E. L. TOMKINS, M.D.

This term is applied to a little-known affection. The most important paper on the subject is one by Dr. John Wyllie, published in the Edinburgh Hospital reports, 1895. He says that it is a common practice for nervous and hysterical patients to take air into the œsophagus and stomach, and then bring it up in frequent and noisy eructations. They complain of "wind"; their eructations are frequent and loud, and can be produced voluntarily. If a cork be introduced between the teeth, so as to keep the mouth open, in a great number of instances the patient instantly loses this power, because she cannot gulp air into the œsophagus. Pitres (*Progrès Médical*, 1895) states that ancient writers described, under the name "morbus ructuosus," a disease in which the principal symptom was frequent belching, and that whilst this, in most of the cases, was evidently due to flatulent dyspepsia, in some they appeared to be of purely nervous origin. Thus Petrus Borellus tells the history of a man who was inconvenienced by belchings so frequent that he was obliged to let the gas escape during conversation between every two or three words. J. P. Frank, in his once-standard "Practical Medicine," reported a series of cases in which eructations were provoked by cutaneous excitation. Dr. Tompkins relates the following case.—A married woman, aged thirty, of a nervous disposition, sustained severe shocks from the sudden death of relatives. Belching so severe that she could hardly breathe came on. She thought she had indigestion, and was treated without avail. At the end of three months the eructations were at the rate of from thirty to forty a minute. Bromide of sodium, pepsin, and charcoal, were given until bromism was pro-

duced, but the belching continued. The constant current applied to the phrenic nerve stopped the belching instantly; but the hysterical nature of the affection was shown when the same result was produced by applying the electrodes to other parts. Eventually she recovered, but was liable to relapses whenever exposed to worry or shocks.

In connection with this subject see also "Rectal Aspiration," p. 115.

GAZETTE DES HÔPITAUX, Oct. 13.

The Treatment of Aneurysm by the Subcutaneous Injection of Gelatine.

The value of gelatine as a hæmostatic in various conditions — epistaxis, hæmoptysis, hæmatemesis, metrorrhagia, and in the treatment of aneurysm have been pointed out in the last few years by several French writers. In 1895 M. Dastre found that intravenous injection of gelatine in a dog rendered the blood more coagulable. As the blood has a tendency to coagulate in contact with a vessel which is not perfectly smooth, and in most aneurysms the sac is lined with a layer of fibrin, it is easy to comprehend that if the coagulability of the blood were increased the deposit of fibrin would be more rapid and complete, and perhaps sufficient to cause obliteration of the sac. Such was the reasoning which led M. Lanceraux and M. Paulesco to employ this remedy in a case of aneurysm of the aorta, brought before the Académie de Médecine, in 1897, which confirmed this theory. The patient was a man, aged 46, who had an enormous aneurysm of the arch of the aorta. In the anterior superior part of the thorax was a pulsatile tumour, as large as an infant's head, measuring twelve centimètres in diameter.

The right, second, third, and fourth costal cartilages and the extremities of the corresponding ribs, and a great part of the sternum, were eroded. The sufferings of the patient were great, the tumour increased to fourteen

centimetres in diameter, ecchymotic bosses, soft and depressible where the blood was in direct contact with the thinned skin, formed. The situation was critical. Fifty c.c. of a sterilised solution of gelatine (1 in 100) in a solution of Na-Cl (1 in a 1,000), at a temperature of 98°6, were injected into the subcutaneous tissue of the buttock. On the following day the tumour was firmer; day by day it diminished, and the pains completely disappeared. But soon it recovered its original size and the pains reappeared. A fresh injection of 150 c.c. was followed by the same result as the first. After that a dozen injections of from 150 to 250 c.c. were given at intervals during the next three months. The tumour diminished until it measured only two centimetres by one. It was very firm, and no longer showed expansile pulsations.

MM. Lanceraux and Paulesco returned to this subject at the meeting of the Académie held on October, 1898. The good result in the case described was maintained for a year, but suddenly a detachment occurred and the blood penetrated between the clot and the wall of the sac, forming a pulsating pocket. Injections of gelatine again produced coagulation here.

The second case was one of aneurysm of the arch of the aorta compressing the superior venacava and causing venous stasis of the head, neck, and superior thorax. These symptoms disappeared under the same treatment.

A no less satisfactory result was obtained in a case of right subclavian aneurysm which compressed the brachial plexus and caused acute suffering. The aneurysm diminished, and the pains and pulsation disappeared. A remarkable fact in this case was the reappearance of the radial pulse.

The writers claim this efficacy of gelatine in saccular aneurysms only; the slowing of the blood current, which is indispensable for the deposit of fibrin, being absent in fusiform aneurysms.

In the discussion which followed, M. Huchard also reported good results from this

treatment, but he recommended that the iodide of potassium treatment should not be neglected. He added that these injections were not without danger, a case in which fatal embolism was possibly produced by them had been mentioned.

M. Lanceraux, in reply, did not wish to disguise the dangers, he always recommended the greatest caution in beginning the treatment, but he never had any accidents.

ARCHIVES GÉNÉRALES DE MÉDECINE,
September.

The Microbial Origin of Gall Stones.

Professor Gilbert, to whom belongs most of the credit of establishing this theory, publishes an important paper. As far back as 1886 microbes had been found in biliary calculi by M. Galippe. In conjunction with M. Dominici and M. Fournier, M. Gilbert has shown that the microbe of the calculi is the colon bacillus, the ordinary invader of the biliary passages, the usual pathogenic agent in angiocholitis and cholecystitis. Other microbes may be found, notably the typhoid bacillus. These writers found the colon bacillus, living or dead, in the centre of the calculus in a third of the cases, and they observed that the calculi containing living microbes were recent, whilst those containing none or only dead ones were old.

Parallel to these bacteriological researches on the calculi of man is the experimental production of calculi in animals. In 1893 M. Gilbert and M. Dominici noticed in the gall bladder of a rabbit, in which they had produced typhoid cholecystitis and angiocholitis, greenish concretions. In 1897 they found in the gall-bladder of a dog inoculated with the colon bacillus a small perfectly formed biliary calculus. But to M. Mignot, who also publishes a paper in this and the preceding numbers of the *Archives*, is due the credit of having completely investigated the subject of experimental cholelithiasis. In man calculi are known to form around foreign

bodies in the gall-bladder. In animals M. Mignot has found that sterilised non-irritating foreign bodies—such as cotton wool, silk thread—introduced into the gall-bladder, do not give rise to calculi, but when impregnated with non-virulent cultures of various microbes—colon bacillus, streptococcus, staphylococcus—calculi are formed. Virulent cultures, on the other hand, give rise to intense cholecystitis, but not to calculi. When non-virulent microbes without any foreign body are introduced, calculi may be formed, but as often are not. They are liable to be carried away by the bile when there is no foreign body to act as a nidus. The two factors in the production of the calculi were slight catarrh of the mucous membrane, due to the proliferation of microbes, and incomplete stagnation of the bile from the presence of foreign bodies. Complete stagnation was incompatible with the formation of true stratified calculi.

M. Mignot draws an important practical conclusion from his experiments. If, in the performance of cholecystotomy, calculi in process of growth are encountered, it is probable that more will be produced. Immediate closure of the gall-bladder (ideal cholecystotomy) should therefore be performed only when the asepsis of the gall-bladder has been assured.

ANNALES DE GYNÉCOLOGIE, September.

Generalised Gonorrhœal Infection.

The rarity of general gonorrhœal infection has caused M. J. Hallé to publish the following important case:—

A woman, apparently robust, aged thirty, was admitted to hospital. For ten days she had been obliged to suspend work in consequence of pain in the hypogastrium and iliac fossæ, aggravated by walking, and accompanied by backache. Examination showed only a little tenderness of the abdomen. The uterus was mobile and a little painful. There was no fever, the heart and lungs were normal, and the tongue was healthy. Abundant metrorrhagia occurred; in a few days it

became worse, and was accompanied by a rigor and temperature of 101.3° . The metrorrhagia passed off after five days, but the fever and rigors continued. Physical examination of the genital organs again gave no result. The case assumed the aspect of pyæmia, the temperature ranging daily from normal to about 103° F.

The patient was supposed to be suffering from infectious metritis. A sterilised tube passed to the fundus of the uterus brought away some serous fluid in which the gonococcus was found. Intrauterine injections of permanganate of potash were used. Phlegmonous peri-arthritis of the left elbow occurred, and from cloudy serous fluid removed by puncture the gonococcus was again cultivated. A diastolic cardiac murmur and pericardial friction were heard. The patient became worse, her complexion assumed an earthy tint. She died at the end of six weeks.

The necropsy showed lymph and serous fluid in the pericardium, typical vegetating endarteritis of the aortic valve, but no signs of the disease in the pelvis. The gonococcus was found in the aortic vegetations and in the pericardium, but not in the uterus. No other organism was found.

This case is important in several respects. The localisation of the infection in the uterus to the exclusion of the vagina and the urethra was unusual. Above all, it removes all doubt that the gonococcus alone is (for no other organism could be found) capable of producing endocarditis and other visceral lesions. Some writers have alleged that when such complications occur the gonococcus is associated with other organisms of greater virulence, such as the streptococcus. M. Hallé believes that the gonococcal infection was not of recent date as the vagina and urethra, its usual portals of entry, were free.

LYON MEDICAL, Sept. 25.

Multiple Neuritis in Mumps.

Even the most trivial of the infectious diseases are, at times, accompanied by serious

and fatal complications. In mumps, nervous complications have been frequently observed, especially nerve-deafness, which remains permanent. M. Gallavardin publishes an important paper on the multiple neuritis of mumps. The paralyzes of mumps can be divided into three classes—(1) facial paralysis from the direct action of the parotiditis, of which only one example has been published, (2) cerebral paralysis, often in the form of hemiplegia, of which six cases have been published, (3) paralysis, due to peripheral neuritis—of which he relates the following example:—

A woman, aged thirty, at the end of the sixth month of pregnancy, had an attack of mumps. On the eighth day sensory troubles—general itching and pain—became evident. Paresis and then paralysis, affecting the trunk and the four limbs, with ataxia, came on. In the hands there was disassociated anæsthesia—abolition of the sense of touch, but preservation of that of heat and pain. The muscular sense was entirely lost. The plantar and patellar reflexes were abolished. The abdomen became tympanitic. Dyspnœa, unexplained by any signs of disease in the lungs, occurred, and necessitated the induction of premature labour. The patient gradually recovered.

M. Gallavardin insists that the neuritis was due to the mumps and not to pregnancy, for the first symptoms occurred on the eighth day, exactly as in other cases, and the intractable vomiting, which, according to M. Vinay, always precedes the neuritis of pregnancy and seems to be its cause, was absent. He has been able to find three other cases only of multiple neuritis from mumps in French, and none in foreign literature. Two cases of optic neuritis have also been published:

From his own, and the other, cases, he constructs a general description of the multiple neuritis of mumps: it manifests itself, a few days after the onset of the disease, by sensory troubles followed by motor paralysis of the four limbs, from which the recovery is gradual.

LA SEMAINE MÉDICALE, Sept. 14.

Grafts of Living Bone.

At a meeting of the Académie de Médecine M. Berger reported the result of M. Ricard's work on this subject. In a case of sarcoma of the frontal bone, M. Ricard, after removing the tumour, filled the gap with a piece of the hip-bone of a dog, removed at the same moment. Five years afterwards the patient returned with generalised sarcoma, but without local relapse and the persistence of the osseous graft could be perceived. The experiences of Ollier Adamkiewicz and Mosse show that grafts of bone made from one animal to another are usually absorbed, totally or partially. Sometimes they are replaced by a cicatrix so firm that the persistence of the graft might be inferred.

M. Ricard's second patient was a young woman whose nose had fallen in from destruction of the septum. Two attempts were unsuccessfully made to restore the form of the nose by a metallic support, after the method of Martin, of Lyons; but ulceration of the skin occurred. M. Ricard divided the integument of the nose in the middle line, carefully dissected the skin from the mucous membrane, introduced between them the fourth metatarsal bone of the patient, removed at the same time and fashioned as required; he then united the integument over the bone. This graft was tolerated and the deformity corrected. But it was absorbed in time and replaced by a mass of fibrous tissue, which, however, maintained the result as regards form.

M. Berger agrees with M. Ricard that grafts obtained from the subject have not a great advantage, as regards absorption, over those obtained from animals, and is disposed to return to the latter in his next operations.

REVUE DE MALADIES DE L'ENFANCE, Oct.

Nephritis after Vaccination.

The almost invariably benign course of vaccinia causes it to be regarded as almost a local affection. But it is an exanthem in

which the eruption is suppressed and virulence reduced to a minimum. However, as if to remind one of this, in very rare instances a true exanthematous rash resembling variola breaks out, and the case may prove fatal. Similarly, complications common to the exanthemata occasionally occur, for example, nephritis.

In the *Revue de Maladies de l'Enfance* appears an account of the following case, published in "Jahrb. f. Kinderheilk," 1898, p. 22, by Th. Frölich, from the clinique of Prof. Johanessen. A boy aged $6\frac{1}{2}$, some days after vaccination, became depressed, morose, and somnolent; on the eleventh day he had œdema of the face and scrotum. The urine contained blood, albumen in notable quantity, and casts. There were no other signs of disease. Under treatment the albuminuria and hæmaturia gradually disappeared, and at the end of three weeks the urine was normal.

Similar cases have been published by Senator, Perl, Falkenheim, Peiper, and Schnaase.

BERLINER KLINISCHE WOCHENSCHRIFT,
September 12.**Tendon Grafting.**

Dr. O. Vulpius reviews a number of cases where tendon grafting or transplantation was performed for paralysis, with or without deformity of the foot and hand. Originally introduced by Nicoladoni in 1882 for paralytic club-foot, the operation has only recently become well known, and used in a great variety of conditions, including traumatic peripheral paralysis, poliomyelitis, cerebral paresis, congenital spastic paralysis, and Little's disease. In the lower extremity the results, especially in paralytic club-foot, have been excellent. Deformity, if present, must be corrected first in the usual way. The principle is to connect the tendon of a healthy with that of the paralysed muscle. If possible, the healthy muscle should be one functionally unimportant, such as the sartorius, but if such be not available, the tendon of the

healthy muscle may be split, possibly with some of the muscle itself, and joined to the peripheral end of the paralysed tendon, or the tendons may be joined laterally ("lateral anastomosis").

The author calls attention to the fact that, though the method has been used mostly for the lower extremity, its importance is still greater in paralysis of the upper, especially of the wrist and hand.

In the latter the application of apparatus, or the fixation of the joint (arthrodesis), are useless, and hitherto, therefore, paresis of the upper extremity has been looked upon as almost hopeless. The following cases are examples:—

(1) Kryuski treated an injury which had divided the flexor tendons of the middle finger in the palm by suturing the peripheral end of the cut flexor profundus to a piece split off from the flexor tendon of the fourth finger, and the peripheral end of the flexor sublimis to the tendon of the index finger. Complete recovery followed.

(2) In a case of right spastic hemiplegia, where the wrist and fingers were so sharply flexed as to be useless, Rochet (*Lyon Méd*, No. 34, 1897) divided the whole of the atrophied extensors $2\frac{1}{2}$ inches above the wrist joint, and also the palmaris longus and flexor sublimis. The peripheral ends of the extensors were then passed through a wide opening in the interosseous space, and joined to the central ends of the above-named flexors. Five months later the hand was straight. Flexion was performed by the flexor profundus, active extension was very limited, but the fingers could be straightened, especially the thumb, and the hand could be used for holding articles. This case is especially interesting as an example of the conscious and unconscious cerebral effort necessary to produce the required effect when a muscle is set to do work antagonistic to the normal. Extension was performed by a flexor, and the function of the super-

ficial and deep flexors had to be entirely separated.

On the whole, owing to more complicated conditions, the results of tendon grafting in the upper, have not been so brilliant as in the lower limbs. Still, any improvement, however slight, in the hand is of immense value, and better results may be expected with further experience.

BERLINER KLINISCHE WOCHENSCHRIFT,
September 5.

The Arrest of Uterine Hæmorrhage by the Local Application of Steam.

By Prof. A. DÜHRSEN.

The method of arresting hæmorrhage by steam was first employed by Sneguireff, of Moscow, in 1894, for profuse hæmorrhage during the removal of an echinococcus cyst from the liver. Since then experiments have shown that parenchymatous organs can be incised almost bloodlessly, and that hæmorrhage from arteries of the size of a dog's femoral can be quickly arrested by a steam jet, Prof. Dührssen has used the method for uterine hæmorrhages with excellent results. The technique is simple. A fenestrated uterine catheter is joined by a gutta-percha tube to a small boiler. The steam issuing from it should be at 212 deg. F. Higher temperatures are advocated by some, but the author has never used them except in experiments on animals. In this way dangerous uterine hæmorrhage can be arrested permanently and painlessly without an anæsthetic; and serious operations—for instance, hysterectomy for fibroid tumours—may often be avoided.

The details of the procedure differ according to the age of the patient. (1) If the steam is allowed to act for two minutes, exfoliation of the uterine mucous membrane follows, either *en masse* or piecemeal. A raw surface is left which eventually forms adhesions, which cause obliteration of the cavity, and subsequent atrophy of the uterus, and

hæmorrhage is cured as certainly as though the uterus had been removed. In order to exclude cases which are unsuitable for this treatment, such as malignant tumours or placental remnants, the cervix must always be dilated first. An important detail is that the instrument, where it passes through the cervix, must be encased in a drainage tube, for otherwise the heat may damage the cervical walls, and be followed by obliteration of the cervical canal and hæmatometra.

Cases in which this treatment is indicated are exhausting floodings between the age of forty and fifty, whether caused by chronic metritis, by abnormal friability of the walls of the uterine vessels, or by small interstitial myomata. In this last case the steam probably produces atrophy of the myoma as well as of the uterus. Where it is required to arrest abnormal uterine hæmorrhage without causing obliteration of the uterine cavity, as in young women with too profuse menstruation, the steam must not be allowed to act for more than a quarter of a minute (Sneguireff says one minute, which is certainly too long), and the process should not be repeated until after the next menstrual period. The application of steam for a quarter of a minute successfully sterilises septic endometritis in puerperal fever, and the raw granulating surface left offers an excellent barrier against the further entry of bacteria into the circulation. Good results have also been obtained in subacute and chronic gonorrhœa, and the author suggests its use as an abortive treatment for acute cases.

If carried out properly the treatment is quite harmless, and has no disadvantages.

BERLINER KLINISCHE WOCHENSCHRIFT,
Aug. 8.

Multiple Tuberculous Strictures in the Ileum Cured by Resection.

Prof. Lennander, of Upsala, reports an instructive case. A woman, aged thirty-seven, was treated in hospital in January,

1896, for catarrhal appendicitis. Admitted again in July, the vermiform appendix was removed, and she was discharged "cured." She directly afterwards suffered from vomiting and colic, which continued off and on till she returned to hospital again in January, 1897. At the laparotomy then performed the disease was found to be tuberculosis of the small intestine and mesenteric glands. There were four strictures in a coil of ileum. This piece, 16 in. long, was resected with the attached portion of diseased mesentery, and the intestine joined by end to end anastomosis with a Murphy's button. The points of interest are—(1) absence of signs of tuberculosis elsewhere; (2) the multiple strictures in the ileum caused by healing of circular tuberculous ulcers; (3) the previous (probably non-tuberculous) relapsing catarrhal appendicitis, which masked the symptoms of tuberculosis; (4) the retention of the button. The case shows also how important it is in treating relapsing appendicitis to think of other possible diseases in neighbouring organs. The further history of the case was equally interesting. The woman was able to work till January, 1898, when she was again admitted for colic, suggestively biliary. The Murphy's button could be felt quite plainly, and another laparotomy was performed. It was then found that adhesions had produced a kink in the transverse colon just underneath the gall-bladder, which was itself free. These which no doubt had caused the colic, were removed. The lumen of the intestine where it had been joined was normal, but there had been formed, probably by the weight of the button, a diverticulum 5 in. long. This was removed, together with the button it contained. This proves that a Murphy's button of a size suitable for the intestine may not be able to pass the ileocecal valve. While the woman was in the hospital on the last occasion there was no trace of tuberculosis. Prof. Lennander concluded that the intestinal tuberculosis was primary, and that it had been cured by the operation.

BERLINER KLINISCHE WOCHENSCHRIFT,
August 22.

Resection for Myeloid Sarcoma.

By Dr. KAREWSKI.

Formerly sarcoma of the bones was considered to be a strict indication for amputation of the entire limb. Lately, however, many complete and permanent cures have been obtained by resection of the bone in its continuity, or even by simple scraping with the sharp spoon and chisel. The latter procedure was adopted in the case of a woman, aged twenty-six years, who developed a fluctuating swelling the size of a fist over the internal condyle of the right tibia. An exploratory incision showed this to be a myeloid sarcoma growing from the cancellous tissue of the upper epiphysis of the tibia. The whole of the internal condyle, including the greater part of the articular surface, was removed by the spoon and chisel. Microscopically the tumour proved to be a giant-celled sarcoma.

After the operation there was no new formation of bone, and at first an instrument was required to make walking possible, but afterwards the bony defect was filled up by a celluloid plate with perfect success. Sixteen months later the woman was in excellent health, with no sign of recurrence. This operation is indicated for giant-celled sarcomata only: amputation is still necessary for the small-celled varieties.

MÜNCHENER MEDICINISCHE WOCHENSCHRIFT, Nos. 40 and 41.

Pregnancy Complicated by Chronic Valvular Disease of the Heart.

Dr. R. Jess discusses the question of the influence of pregnancy on chronic heart disease, about which there is considerable difference of opinion. Those who base their statistics on hospital in-patients give the maternal mortality, as a direct result of a labour complicated by heart disease, as from 7.1 to 71.4 per cent., while in twenty-nine women with this complication, representing

114 births in the Kiel "poliklinik," the writer found but one death to be due to this cause, though all the women were confined at home amidst bad surroundings.

The important question, whether a woman with heart disease ought to marry, may be answered, with certain reservations, in the affirmative. In this Dr. Jess agrees with Kisch (*Therapeut. Monatshefte*, February, 1898), though others, among whom are Schlayer and Peter, would forbid marriage absolutely. The following considerations are of importance in deciding the question:—

1. Practically marriage is not so dangerous as it appears theoretically. High death rates in pregnancies complicated by heart disease may often be explained by the statistics being based on in-patients, who are always chosen from the worst cases.

2. There must be satisfactory compensation of the valvular disease. In such cases the first few pregnancies have little or no effect on the heart. The danger increases, however, with every child. Hence the danger of repeated pregnancies must be pointed out to the patient.

3. Pregnancy undoubtedly aggravates advanced and uncompensated heart disease, and the ground lost in this way may never be recovered. Marriage must then be forbidden.

4. The most dangerous form of heart disease is uncompensated mitral stenosis. Jess, in his opinion, is opposed to Spiegelberg, who states that aortic disease is the worst.

The dangers are naturally much greater for working girls, who cannot have proper rest and attention during pregnancy.

The treatment both of pregnancy and labour, when this complication is present, requires great care. Failure of compensation may often be averted by rest and suitable diet; or, if these fail, by drugs, such as digitalis. The question of inducing abortion may arise. This should be put off as long as possible, as the prognosis after induced abortion is unfavourable. All Schlayer's cases ended fatally. It is seldom called for, since urgent

symptoms usually begin late in pregnancy, when the time for the induction of abortion is past. When labour has commenced it should be terminated as quickly as possible by forceps or version. Ohlshausen recommends that, as soon as the head has passed the vulva, a sand-bag weighing 8 lb. to 10 lb. should be placed on the abdomen, to prevent collapse from the sudden sinking of the abdominal pressure. Brandy and other stimulants should always be given.

THERAPEUTISCHE MONATSHEFTE, Sept.

(p. 494.)

Gastric Ulcer.

By DR. CZYGAN.

The diagnosis of gastric ulcer is often most difficult. Even hæmatemesis, the most reliable symptom of all, occurs at times in cases where the necropsy shows no sign of injury to the lining membrane of the stomach. The stomach may bleed "like the nose," and no trace be discoverable of the site of the hæmorrhage. This difficulty of diagnosis renders it unlikely that surgical treatment should become common; although attempts have been made to excise the ulcer, and to facilitate the transmission of the gastric contents by widening the pylorus, or by establishing an artificial communication between it and the intestine. For purposes of medical treatment the disease is divided by Dr. Czygan into three stages—(1) that of acute symptoms, such as pain, vomiting, and hæmatemesis; (2) that in which all the symptoms have diminished in intensity; (3) that in which the patient feels well, but where actual lesions still exist, and require treatment. The article contains no fresh suggestions for treatment of the first stage. In the second period the load carried by the stomach must be diminished. For this purpose the food must be carefully regulated, and the bowels kept active. Injections of oil, or oil and water, (Fleiner), are recommended, and food which may overtax the weakened stomach

should be avoided. Undue acidity of the gastric juice is corrected by doses of *magnesia usta* after meals, and care should be taken not to over-excite the gastric glands. Very hot or very cold food, acids, and spiced dishes, are therefore contra-indicated. Carbo-hydrates should be allowed in small quantities only, and milk and eggs are best avoided. In the third stage, the general health demands attention, as the ulcer, if healed, is for some time liable to break down. Massage and electricity are useful, and careful dieting is still needful. Strychnine is recommended as a stimulant to the gastric muscle. If actual organic mischief, such as kinking or stenosis of the pylorus, has occurred in the process of healing, surgery is the only resource. Finally, the exciting or predisposing causes, such as atony of the stomach and hyperacidity, should be treated.

DEUTSCHE MEDECINISCHE WOCHENSCHRIFT, September 1.

Experimental Tuberculous Endocarditis.

Drs. Michaelis and Sanford Blum claim to have produced typical vegetative endocarditis experimentally. For some time past it has been known that always ulcerative, and occasionally vegetative, endocarditis are produced by a variety of micro-organisms, generally streptococci, staphylococci or pneumococci. Rokitansky's theory, that tuberculosis and endocarditis were mutually antagonistic, has been proved to be untenable. Thus, Frommhold found valvular disease of the heart to be present in 22 out of 277 cases of tuberculosis, or in 8 per cent., and to be commonest in aortic disease. It was not till 1896 that tubercle bacilli were found in the valvular endocardium, when von Leyden published three consecutive cases. Since then they have often been demonstrated in this position in endocarditis accompanying phthisis. But, it is often impossible to do so, and some have tried to explain

the endocarditis by the irritation of toxins; while others have doubted the possibility of its production by tubercle bacilli at all. Hence the writers' experiments are of interest. They made holes through the aortic valves of rabbits, and injected an emulsion of tubercle bacilli into the vein of the ear. Three to six weeks later the animals died. The necropsy should diffuse tuberculosis, the heart—especially the left ventricle—enormously dilated, and the aortic valves covered with delicate warty growths, in sections of which were demonstrated typical tubercles with bacilli. In no case was any other kind of organism present. The writers' believe the frequent failure to find tubercle bacilli in the vegetations of heart disease complicating phthisis in man to be due to the extreme difficulty of staining them in sections. These experiments prove definitely that the tubercle bacillus by itself can cause endocarditis verrucosa, and support Klebs' theory that the vegetative, as well as the ulcerative, form is always infective.

JOHNS HOPKINS HOSPITAL BULLETIN.

Medical Fees in Ancient Greece and Rome.

Such is the subject of an interesting paper by Bombaugh. The first medical fee of which he finds specific mention was one recorded by Herodotus as given by Darius to Democedes of Crotona, a slave of Oroetes, and consisting of two pairs of fetters of gold. In his day, in Greece, the usual fee paid to physicians for incidental visits was very small, in fact, not more than two groats, 16 cents, or about one-thirtieth of the customary fee in England in our time, one guinea. It was customary for physicians to be engaged by the year by the municipality, and paid from public funds. According to Pliny, Cleombrotus received 100 talents for his treatment of King Antiochus—£24,375 if the Attic talent is meant, £31,200 if the standard coin of the Ptolemies. Every Greek city had not only one or more public

medical men in the municipal service whose duty it was to visit the sick in the city and suburbs, but there was also a large dispensary, "iatrium," where the practitioner, aided by his pupils, held consultations, performed operations, and distributed medicines. Beds were reserved for patients who could not be removed, or for very serious cases.

The rich being able to be cared for at home, those who needed the aid of the public dispensary were the poor. Yet, in the state of society at that period, the isolated poor, those without patron and without brothers, as the phrase went, meaning those who were not members of a society having a mutual benefit fund, were not numerous. But what poor there were, were faithfully attended to in accordance with the precept of Hippocrates. Inscriptions show that it was an obligation that was gracefully and generously fulfilled. In the Roman empire, "no Roman till Pliny's time had ever vouchsafed to practise physic; that office was only performed by Greeks," says Montaigne in his essays, "and medicine, therefore, was in the hands of the slaves. In order to attract the Greek physicians to Rome, Cæsar gave them the 'jus Quiritium,' and afterwards Augustus exempted them from taxation." Under the superintendence of the "archiatri," Romans later became practitioners, the first physician bearing the title being Andromachus, the medical adviser of Nero. During the reign of Nero the "archiatri" were divided into two classes—the physicians of the different quarters of the city, "archiatri populares," and the physicians of the palace, "archiatri palatini." The former were assigned to the relief of the poor, and each city was provided with five, seven, or ten, according to its size. Rome had fourteen, besides one for the vestal virgins and one for the gymnasia.

The latter, the "sancti palatini," were men of elevated social position, and of high rank, not only in the exercise of their profession but as counsellors of the Government. Both

were paid salaries and were allowed special immunities and exemptions. Later on, in the time of Hadrian and Antoninus, such concessions were made still more liberal, and the chief "archiater" ranked as vicegerent. While the "populares" were obliged to attend their poor patients gratis, they were allowed to receive fees from the rich. They were not appointed by the municipal authorities, but were elected by the people, and while their office was less honourable than that of the "palatini," it was more lucrative. In the time of Vespasian they had a retiring pension. According to Pliny, at the beginning of the Imperial reign eminent physicians made 250,000 sesterces, or about £1,950, per annum, and Quintus Stertinius, the favourite of the Emperor Claudius, "was content with the honour of serving the Emperor at the rate of 500,000 sesterces (£4,000) per annum, though his fame was such that he might have made 600,000 sesterces, or £5,000, in private practice." To-day, in the Vatican, "among the clustered family of the Cæsars," may be seen a statue of Musa, the physician of Augustus, placed among "his family group of bronze and marble memorials as one of the highest honours he could bestow."—*Globe*.

MEDICAL SOCIETIES.

BRITISH MEDICAL JOURNAL, Oct. 1.

BRITISH MEDICAL ASSOCIATION.

Different States of Vascular Pressure and their Management.

Sir William Broadbent's address on this subject, which he has done so much to elucidate, is in many ways of practical value. He said that in feeling the pulse it was by the full and tense or empty and flacid condition of the vessel, between the beats, that the best idea of the degree of obstruction at the periphery, which is the essential element of vascular pressure, was got. A pulse below the average tension was often found in

long-lived families. Debility, as such, was not necessarily attended with low pulse tension, and an abnormally low tension did not necessarily indicate weakness, but there were striking examples of the association of low tension with special forms of debility—for example, epilepsy. Unduly high was more common than unduly low pressure; it ran in families; the high tension pulse was found in children, and the tortuous arteries, usually associated with age, in young men. The states of the system with which it was associated—renal disease, lead poisoning, gout, constipation—were characterised by imperfect elimination. The effects were hypertrophy and degeneration of heart and vessels.

For many years he had taken the plus or minus tension of the pulse as a guide in prognosis and treatment of the multitudinous nervous derangements named neurasthenia. When the tension was high the prognosis was better than when low. There was the possibility that the blood impurity which gave rise to the peripheral resistance might also be a poison to the nervous system, causing a sense of intense depression, and capable of elimination. An illustration was the effect of a blue pill which sometimes seemed to change the entire aspect of the world to the sufferers from what is called biliousness.

Dr. Craig had shown that in melancholia the vascular pressure is high, in maniacal excitement low, and that modification of the tension is attended with more or less of a corresponding effect on the symptoms. This explains the disappointing results of hypodermic injections of morphine in states of excitement. Instead of sleep there was often an aggravation of the excitement, resulting from the lowered vascular pressure produced by the morphine. Similarly this effect of morphine was an important factor in its favourable influence in angina pectoris and in relieving the distress of aortic incompetence. Sir William thought that vascular pressure

might be a means of discriminating between cases which required different treatment in epilepsy, the two extremes of tension were met in association with the periodical attacks, when the tension was low the prognosis was more unfavourable than when it was high.

He thought that uræmic convulsions were directly related to high pressure, and produced by arrest or disturbance of the capillary cerebral circulation, and not by the mere presence in the blood of any urinary poison. Uræmic convulsions did not follow ligation of the ureters, and could not be produced by injecting urea, or any renal derivative. They supervened when the accumulation of such poison could not be great, and were often absent in highly uræmic states of the blood. Identical convulsions were seen when no renal disease was present, but high arterial tension due to some other cause.

Another affection in which the clue to treatment was often furnished by the vascular pressure was chronic bronchial catarrh. The term gouty bronchitis was not a mere refuge of ignorance. In many cases of recurrent bronchial catarrh the pulse was often high, and the blood charged with uric acid, or some other nitrogenous waste which in some way predisposed to the catarrh. Attacks might be warded off by wintering in the south, but much more effectual relief was afforded by eliminants.

He pointed out the association of Cheyne-Stokes breathing with high tension; in hundreds of cases he had never seen it absent.

In the treatment of low pressure the underlying vice of nutrition should be first ascertained; the cardiac vascular tonics, digitalis, and the like were often useful.

When the vascular pressure was high elimination was indicated. Regulation of the diet was important—limitation of nitrogenous food and alcohol. The elimination might be cutaneous by means of exercise, baths, and diaphoretics; renal by copious draughts of water apart from meals, alkalies and other diuretics; hepatic, or alvine, according to the

case. The aperient was not a matter of indifference. Mercury ought to form a part: it produced a greater effect in lowering arterial tension in a small dose than much more powerful purgation by other aperients. A wide-spread opinion prevailed that mercury ought never to be given when there was albuminuria; there could be no greater mistake. For the relief of high pressure in emergencies, as in angina pectoris, the vascular relaxants—amyl nitrate, nitro-glycerine, and nitrate of sodium—were invaluable when an immediate effect was required; erythol tetranitrate was of the greatest permanent benefit.

BRITISH MEDICAL JOURNAL, September 17.

BRITISH MEDICAL ASSOCIATION.

Cardiac Disease and Life Assurance.

The discussion on this subject cannot be said to have added much to our knowledge. Sir William Gairdner's address consisted rather in pointing out the want of data than in the enunciation of any new principles. He related the following cases.—

MITRAL REGURGITATION: DISAPPEARANCE OF MURMUR.—A medical practitioner had a mitral regurgitant murmur in early and middle life, apparently from rheumatism. He had occasional attacks of angina, but carried on a busy practice. The murmur, after lasting thirty years, finally disappeared, and the cardiac disease passed into abeyance. He died between 60 and 70 years of age of disease which had no connection with the heart.

POST SYSTOLIC MURMUR: ACTIVE LIFE WITHOUT SYMPTOMS.—A boy, aged ten to twelve, had a loud hollow-toned blowing murmur following the first sound (? pulmonic or aortic). He grew into manhood, became the father of a family, and engaged in active exercises—grouse shooting, etc.—and the murmur almost disappeared.

Sir William Gairdner said that statistics, and not these isolated cases, were required for calculating risk. He then discussed the different cardiac diseases seriatim.—

PERICARDIAL LESIONS.—Murmurs, or quasi-murmurs, which seem to be prolongations of the first sound, were sometimes heard, especially over the base and right ventricle. Many of these were exocardial and produced by a batch of thickened pericardium, the remains of extinct pericarditis. They were of no prognostic importance. He thought that well ascertained acute pericarditis might heal, leave no adhesions, and not affect insurance risk.

ORGANIC LESIONS WITHOUT FUNCTIONAL DISTURBANCE.—The proposal should be deferred for a few years, and an extra premium charged, if then accepted.

SENILE DEGENERATION.—The proposal should be rejected, or a considerable addition should be made to the premiums. Sometimes an insurance for a limited term—five or ten years—may deal with these cases.

FUNCTIONAL DISORDERS.—Irregularity of rhythm might involve no extra risk. As to bradycardia and tachycardia, a vigorous healthy man might have a pulse of fifty; but there were no data to give the risk in the more extreme forms.

Dr. Symes Thompson said that very slow pulse was not, in his experience, as dangerous as Sir William Gairdner had suggested. Life might be prolonged to a great age, although the pulse was barely 28 or 32.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY, October 25.

Fibrinous or Membranous Rhinitis and its Relation to Diphtheria.

Dr. H. Lambert Lack read a paper on this subject. Fibrinous rhinitis, first described by Schuller in 1871, was defined as a subacute or chronic affection of the nose, characterised by a fibrinous or membranous exudation on the nasal mucous membrane. The great interest of the affection lay in its connection with diphtheria, the older observers considering the diseases quite distinct, while the more recent observers, relying on the results of

bacteriological examination, claimed that fibrinous rhinitis was merely a mild manifestation of diphtheria. Cases of the disease were shown to be very common, forming no less than $2\frac{1}{2}$ per cent. of all the children attending the author's hospital practice. The disease was essentially one of children, and occurred most frequently in the autumn months. The chief symptoms were purely local, such as nasal obstruction and discharge, excoriation of the nostrils and upper lip, occasional epistaxis, &c.; sometimes sore throat was seen, presenting peculiar characteristics. The affection was very chronic, lasting on an average six to eight weeks or more. General symptoms were very mild, sometimes altogether absent. Many cases were not seen until late, others probably were often overlooked even by competent observers; the children, not being in any way ill, continued to attend school, &c., as usual. There was complete absence of all paralytic sequelæ. Attention was drawn to cases in which a purulent nasal discharge persisted often for many weeks after true faucial diphtheria. The symptoms of the two diseases, fibrinous rhinitis and true nasal diphtheria, were briefly contrasted. The results of bacteriological examination carried out in thirty-three cases were reported. The true Klebs-Loeffler bacillus was constantly present, generally in pure culture, sometimes mixed with pyogenic cocci, sarcinæ, etc. It was usually of the large variety. It was further shown to be of full virulence on animals, to produce virulent toxins, and to be neutralised by antitoxins. Further, it was shown to be capable of living for several months on culture media, and by its vigorous growth to crowd out other organisms if present. A previous history of diphtheria was found in connection with one case only. The disease was found to be very infectious, and often gave rise to mild sore throat, twenty-five instances of which occurred in eleven families. The Klebs-Loeffler bacillus was also found in healthy throats in associa-

tion with these cases. A comparative investigation showing the frequency with which the bacilli were found in healthy noses was described. The conclusion is that fibrinous rhinitis is a mild variety of diphtheria, the difference in the clinical manifestations apparently depending on some differences in the organisms associated with the Klebs-Loeffler bacillus. The diagnostic value of the presence of the bacillus in sore throats, which did not clinically appear to be diphtheria, was considered to be very slight.

THE JOURNAL OF THE AMERICAN
MED. ASSOCIATION, Oct. 8.

ANNUAL MEETING OF THE AMERICAN
MEDICAL ASSOCIATION.

The Use of Morphia in Bright's Disease.

By SIDNEY RINGER, M.D., F.R.S., Lond.

Few opinions are more dogmatically taught than that opium should not be given in Bright's disease. Many years of investigation have convinced Dr. Ringer that this is wrong. In 1875 Loomis stated that he employed morphia hypodermically in puerperal eclampsia with marked success. He says that morphia may be given to some, if not all, patients with acute uræmia without endangering life, and that it arrests spasm, establishes profuse diaphoresis and facilitates the action of cathartics and diuretics. He has given half a grain of morphia hypodermically to comatose uræmic patients. Flint and Bartholow express similar views. Dr. Stephen Mackenzie (*Lancet*, August 3, 1889), has reported some cases of uræmia, treated by hypodermic injection of morphia. A patient with paroxysmal dyspnœa and weak heart was relieved by $\frac{1}{16}$ grain. He refers to two cases of uræmic convulsions in which recovery followed this treatment. Powell (*Brit. Med. Jour.*, 1885) injected $\frac{1}{12}$ grain into a child, aged 6, suffering from uræmic convulsions due to acute nephritis. The convulsions subsided and recovery followed. Osler says that for the restless-

ness and delirium of uræmia morphia is indispensable, and that since its recommendation by Dr. Mackenzie he has used it extensively, and has never seen ill effects or tendency to coma follow. Dr. Ringer entirely confirms these statements. He finds that morphia hypodermically employed is of conspicuous benefit in the shortness of breath of uræmia. This may be due to different causes. With some patients the compensatory hypertrophy gives way, and they suffer from cardiac dyspnœa, in all respects similar to that from valvular defects with insufficient compensations. The paroxysmal shortness of breath prevents sleep; on falling asleep they are soon wakened by distress of breathing. The patient is compelled to start up in bed, often throws his legs out of the bed gasping for air; or sleep may be distressed and harassed by Cheyne-Stokes breathing. This distressing condition, whether due to deficient compensation in Bright's disease, or to valvular defects, is almost invariably relieved by hypodermic injections of morphia, and several hours' refreshing sleep are secured, to the great relief and comfort of the patient, who on the following day is refreshed, and takes, digests, and assimilates his food better. Morphia can scarcely be too highly commended in such a condition, and although it does not cure, it delays the end and greatly lessens the distress of the declining days of life.

Uræmic asthma, again, yields promptly to hypodermic injection of morphia. On the other hand, persistent distress of breathing may be due to dropsy, the lung being hampered by an abundant serous effusion into the cavity of the chest. Such a condition is not improved by the use of morphia.

The headache and sleeplessness occurring in uræmic patients can generally be removed by the hypodermic injection of morphia. He has not given this treatment in uræmic convulsions or coma, but has largely used it in many cases of uræmia with other troubles, and is sure that morphia may be given to such

patients with every prospect of benefit and no risk.

We think it necessary to add that due care should be used in the use of this powerful remedy. Dr. Mackenzie stated, in the paper referred to, that it should be given "with eyes open to its danger," and it is to be noted that Dr. Ringer does not use it in cases of uræmic coma or convulsions.

SOCIÉTÉ MÉDICALE DES HÔPITAUX, July 8.

Facial Erysipelas Produced by Inoculation of Pus from a Streptococcic Empyema.

M. Ménétrier observed that a number of diseases differing clinically can be produced by the streptococcus — puerperal fever, erysipelas, septicæmia, pyæmia, and membranous sore throat. By inoculating the ear of a rabbit with streptococci from different sources typical erysipelas can be produced. The following case, though the result of accident, presents all the accuracy of a laboratory experiment. Having dressed a patient who had undergone operation for empyema several days previously M. Menetrier scratched himself on the ear. At the time he noticed a little blood on the nail. He had soiled his fingers with the pus and had not yet disinfected his hands. From that evening the scratch was the seat of sharp smarting which increased on the following day, and was accompanied by a sensation of heat in the whole external meatus, and by tenderness of the pre-auricular lymphatic gland. On the next day redness and swelling appeared in the position of the tragus; the lobule of the ear was then involved. On the fifth day the whole ear presented the typical appearance of erysipelas. General symptoms — insomnia, anorexia, pyrexia of gradual onset without rigor reaching to 100.4° F. on the evening of the third day and 102.2° on the sixth — appeared. The erysipelas extended on to the hairy scalp with a well-marked elevated edge. On the twelfth day the whole scalp had been

involved, the eruption was declining, and there was abundant desquamation. But a new patch appeared on the forehead, which extended on to the right cheek. The second attack completely terminated on the twentieth day. M. Ménétrier does not consider any other source than inoculation possible as the cause of the erysipelas. He had not seen the disease for several months. The pus of the empyema was shown to contain streptococci. He also points out that there is a certain analogy between erysipelatous dermatitis and the inflammation and painful tumefaction of the edges of the operative wound with diphtheritic exudation in the wound itself, which are frequently observed in streptococcic empyemata and which he observed in his patient.



Emphysematous Vaginitis. — Fedorotskaia-Viridarskaia (*Ann. de Gynéc. et d'Obstét.*, May, 1898) reports an instance of this vesicular affection of the vagina, which is in most cases associated with pregnancy. The vesicles are full of gas, and are mostly situated in the posterior vaginal wall. They vary in size from a pin's head to a pea, and lie in the submucous connective tissue. Eisenlohr traces this disease to the agency of microbes. He obtained pure gelatine and agar-agar cultures, slightly alkaline. As long as it remained alkaline a culture gave out a gas which seemed to be trimethylamine. Fedorotskaia's patient was in the fifth month of pregnancy. She was feverish, and had rigors and show of blood. The fact that the vesicles contained gas was proved by pricking them, when the vagina was filled with water, bubbles of gas at once escaping. The vagina was washed out twice daily with a 1 in 2,000 sublimate solution. At the end of a fortnight the vesicles had entirely disappeared. It is uncertain whether the cure was due to the injections or to the cessation of gestation. —*Brit. Med. Jour.*

EPITOME OF CURRENT LITERATURE.

MEDICINE.

The Treatment of Septic Peritonitis.—

Dr. Farrar Cobb (*Boston Med. and Surg. Jour.*, Sept. 8, p. 234) claims that in septic peritonitis operation is obligatory. Peritonitis is always caused by bacteria. Some infections are so virulent, and death ensues so rapidly, that none of the usual signs of peritonitis are evident at the necropsy. In two such cases Reichel made active cultures from the shining peritoneal surface. All forms of pyogenic cocci have been found in the exudation. The streptococcus is most to be dreaded, but the colon bacillus may be equally virulent. In general peritonitis from typhoid perforation the typhoid bacillus has never been found; in most cases colon bacilli have predominated; in others, pyococci. However, Körte found the typhoid bacilli in general peritonitis originating from a suppurating gland in typhoid fever. The pneumococcus can cause peritonitis without the association of pneumonia. Gonococci appear to be incapable of causing peritonitis. Infection with any of these microbes will cause peritonitis of varying intensity and character.

Anatomically, Pawlowsky distinguishes four forms:—

(1) An extremely toxic, in which death may occur before reactive inflammation. In some cases the peritoneum is covered with a slimy fluid containing blood corpuscles, fibrin flakes, and many bacteria. The virulence may be so great that death occurs in a few hours, with all the symptoms of shock.

(2) An infection of great virulence, characterised by hæmorrhages and a thin brownish fluid, in which are corpuscles, masses of bacteria, and fibrin (the common form in intestinal perforation).

(3) Fibrino-purulent and sero-purulent peritonitis.

(4) Purulent peritonitis.

But these forms run together, and no sharp division is possible. They depend on the kind of infection, its amount and virulence, and the intraperitoneal and systemic conditions. The less serious forms are the fibrino-purulent and purulent;

the rapidly fatal are the hæmorrhagic. They are usually caused by streptococci, colon bacilli, or pneumococci. But these organisms may, under certain conditions, produce the milder forms. Conversely, staphylococci, which usually cause the latter, may cause the former. Under abnormal conditions bacteria of little or no pathogenic power may cause rapidly fatal peritonitis.

Normally the peritoneum can dispose of bacteria in varying amounts, depending on the virulence of the organisms. The absorption of fluids by the peritoneum is enormous: in an hour it will take up 3 to 8 per cent. of the body weight. This is nature's safeguard against peritonitis. Colonies of bacteria are absorbed by the lymphatics, and carried towards the diaphragm. But death may result from general septicæmia, and not from peritonitis, where large quantities are taken up. Injuries of the peritoneum and the presence of blood clots favour the growth of bacteria. In general peritonitis the lymph channels of the diaphragm are choked by masses of bacteria (Pawlowsky).

From these facts, Clark, of Johns Hopkins Hospital, concluded that slight infection during operations, such as contamination with pus, blood, or septic fluids, could be dealt with by the lymphatics, and that drainage was used too often. His method in such cases is to irrigate the abdominal cavity with gallons of hot salt solution and leave behind 500 to 1,000 c.c., close the abdomen and place the patient for twenty-four hours with the pelvis elevated. Thus he washes out most of the infection, and favours the currents which flow towards the diaphragmatic lymphatics. This method he calls "postural drainage." But it has been abused and used in general septic peritonitis, where free drainage is demanded, for the diaphragmatic lymphatics are clogged with *débris* and bacteria. In many cases of local peritonitis, too, drainage is required for the same reason.

There are infections so virulent and rapid that even at the onset operation is forbidden. Acute puerperal sepsis with peritonitis is frequently an example. Operation for peritonitis will not remove the main source of infection, and hysterectomy is rarely advisable. On the other hand, there are puerperal cases not so acute which have been successfully operated on. Operations for peritonitis with acute septic cholecystitis have been uniformly fatal; cases occurring in the course of advanced

renal and hepatic disease and cases of "terminal peritonitis" are not suitable.

Forty-eight cases of typhoid perforation have been operated on with a recovery of 29.2 per cent.; 142 of perforation of gastric ulcer, with recovery of 41.5 per cent., and of 78 per cent. when operated on within twelve hours of perforation; thirteen of duodenal ulcer, with three recoveries.

In operating Dr. Cobb follows Körte, Finney, and McCosh, whose methods differ very little. The abdomen is opened by a free incision, the intestines are removed from the abdominal cavity (if the patient is not moribund), and kept warm with hot towels. The intestines and the peritoneal cavity are irrigated with hot saline solution and cleansed by gently wiping with gauze pads. Finney lays great stress on the wiping off of flakes of fibrine, which may contain bacteria. If the distension of the intestines is too great to permit of their return they are aspirated or incised and sutured. Drainage with gauze or rubber tubes is always employed. The operation requires plenty of assistance, and must be carefully and thoroughly performed.

Dr. Cobb has operated on seven cases of general septic peritonitis, of which three recovered. We may call attention to the fact that in 1897 Finney recorded five successful consecutive operations for general suppurative peritonitis. He believes that success depends on the thoroughness with which exudations are removed by wiping.

Two Cases of Gangrenous Pancreatitis with Disseminated Fat Necrosis.—Brennecke (*Jour. Am. Med. Assoc.*, Chicago, June 4, 1898), publishes two cases of this rare disease. The first was a woman, aged 47, for years addicted to alcohol, who was suddenly seized with severe cramps in the abdomen, and fell to the ground. She had to be carried home, and the pain was only relieved by morphia. She vomited several times. The bowels were constipated for the first few days. The sharp piercing abdominal pains recurred several times. They were located in the epigastric region, and did not radiate. On admission the abdomen was distended, tympanitic, and tender. There was an area of increased resistance in the right hypochondriac region. The tenderness, through general, was most marked in the epigastric region. The urine showed a slight amount of

albumin, and a few hyaline casts. Laparotomy was performed on the eighth day. The intestinal coils were found matted together by fibrinous exudation. The omentum was thickened, hyperæmic, and studded with small greyish areas, varying in size from a pin-head to a pea. These were foci of typical fat necrosis. The peritoneal cavity, which contained considerable clear straw-coloured fluid, was walled off with iodoform gauze; drainage was established. The pain was much less for a time after the operation. The discharge was at first clear, but soon contained shreds of fibrin. Death occurred twenty-five days after the operation, with symptoms of a slow form of sepsis.

The necropsy showed the omentum, and, to a lesser extent, the parietal peritoneum studded with foci of a fat necrosis, surrounded by a narrow hyperæmic zone. The intestinal coils were adherent to each other and to the omentum, but easily separated. A considerable quantity of bloody fluid was found in the peritoneal cavity. The pancreas was represented by a mass of grey, granular, necrotic tissue, easily torn. The consistence was more liquid in the head and right half. The left half was studded with numerous greyish areas, which fused together in places, forming larger greyish or yellowish masses. These areas were distinctly cheesy and soft, and in places appeared to be formed of retained and inspissated pancreatic secretion.

The second case was that of a man, aged 43, who had also been much addicted to alcohol. He was taken ill one month before admission to the hospital. He began to have severe pains in the abdomen, which required morphia. He vomited constantly. The pains were located chiefly in the epigastrium, but sometimes in the right and left iliac regions. On admission the abdomen was much distended, there was dullness in the flanks and in the right iliac region. His abdomen was diffusely tender, most in the iliac fossa. The pulse varied between 116 and 120, and was very weak; the temperature was usually normal, rising at times to 101° F.; respirations were 28 to 36. An exploratory incision was made six days after admission. As soon as the peritoneal cavity was opened a grey turbid fluid, containing shreds of necrotic tissue and fibrin, escaped. The omentum was much reddened, and studded with white areas. The intestines and omentum were matted together

by fibrinous adhesions. The patient died soon afterwards.

The necropsy revealed well-marked peritonitis. In the omental fat, and to a lesser extent in the abdominal wall, were greyish white patches. The abdominal cavity contained a turbid, greyish red fluid. A large cavity was found in the region of the pancreas. It contained fluid of a dirty yellowish grey colour, mixed with shreds of disintegrated material. The fluid had escaped into the abdominal cavity through a rupture, whose margins were necrotic and of a blueish-grey colour. Stretching across the cavity were remnants of the pancreas, much softened. The entire pancreas was involved in the cavity and contents. The fat tissue around the pancreas contained numerous white areas, like those found in the omentum. A bacillus, corresponding to the cultural and other characteristics of the *Bacillus colli communis*, was found in the blood from the heart, in the spleen, liver, kidney, and in the necrotic areas in the subperitoneal fat.—*Edinburgh Med. Jour.*

Blood Cyst of Sciatic Nerve.—Surgeon-Lieut.-Col. Hatch, M.B., F.R.C.S. (*Indian Med. Gaz.*, Sept.). A healthy-looking man, aged about 40, complained of a tumour, at the back of the left thigh, of ten years' duration. At first it gave him no pain or inconvenience. About a month before admission to hospital it became slightly painful. He complained of pain in the left thigh, increased on movement. A tumour, the size of an orange, was found at the back of the thigh at the junction of the middle and lower third. The skin over it was healthy and slightly shining. The swelling was globular, firm, smooth, and slightly elastic, very movable from side to side, but not up and down. If the leg was flexed, the tumour could be moved more readily. The limb was not wasted. Pain was felt in the tumour and down the leg while walking, which made the patient limp a little. There was no tingling sensation. The femoral glands were not enlarged. The flexor muscles were evidently superficial to the tumour, but spread over it in a thin layer. All the organs were healthy. A longitudinal incision 5 in. long was made over the tumour; the flexor muscles were dissected off the surface over which they were spread in a thin layer. The surface was slightly lobulated and had a bluish ap-

pearance; towards the lower end a yellow spot was seen, and here there was slight bulging. Continuing the dissection up and down, the swelling was found to be connected with the sciatic nerve; a few veins and nerve fibrils ramified over the surface. A small puncture accidentally made on the surface allowed pure blood to escape with considerable force; the opening was closed with forceps, and the nerve fibrils which were in contact with the surface were very carefully separated on both sides. The sac was then completely evacuated, and the trunk of the nerve which was spread out on its deep and anterior surface was defined and the sac removed; a skein of fibres, having been cut near the upper end of the cyst, was sutured. The sac had a thin wall apparently continuous with the sheath in front, slightly yellow in parts and containing pure blood, a little fibrin, and hæmatoidin crystals. Recovery followed.

Rectal Aspiration.—Dr. Marcel Baudouin (*Gazette Médicale de Paris*, May 28, 1898,) publishes an extraordinary case—the second on record—of rectal aspiration, or, as he terms it, *pétomanie*. He published the first case in the *Semaine Médicale*, April 20, 1892. The subject was a man who could first aspirate by the anus and then expel air or liquid in large quantities. He was in the habit of giving public exhibitions of his powers. The second case was that of a married woman, aged about thirty years, the mother of five children. For a long time she had noticed the facility with which she expelled gas from the large intestine, and, thinking that she was affected with some malady, she confided her troubles to a friend who had attended some of the exhibitions just mentioned. The latter assured her that instead of disease she had a fortune. Accordingly she attended the exhibitions and soon learned enough to embark on this strange profession. Having aspirated a large quantity of air into the intestine she expelled it, producing characteristic sounds of various tones and intensities in imitation of laughing, whistling, the quacking of a duck, &c. These sounds were no doubt due to a power acquired over the anal muscles similar to that over the laryngeal. She introduced into the anus a cannula, connected with a tube having a receptacle at the other end into which was placed a lighted

cigarette. The cigarette burnt brightly when she aspirated; the smoke was driven out in a cloud when she expelled the air. But her powers appear to have been inferior to those of her model, to which even the *Temps* devoted an article. He could imitate the sound of cannon, musketry, thunder, the violin, the trombone, and the human voice; and he could even sing in this extraordinary way! However, there is nothing new under the sun, for in the writings of St. Augustine there is a description of these very powers. How is the aspiration of the air performed? Dr. Baudouin observed that with closed glottis the man made a strong inspiratory effort, attended by great depression of the abdominal wall and of the supra-clavicular regions. Negative pressure would be thus produced in the abdomen, which would be enlarged by the elevation of the lower ribs and by the upward movement of the diaphragm towards the thorax. Dr. Baudouin describes the auxiliary muscles of inspiration and probably the diaphragm as assisting in the action. The latter supposition cannot be correct. Contraction of the diaphragm would prevent, not assist, the action. With the inspiratory effort there must be, we should think, relaxation of the sphincter ani. M. Baudouin compares this abnormal power to that possessed by certain individuals over the muscles of the external ear. But a much closer parallel is furnished by cases described by Dr. John Wyllie in the Edinburgh Hospital Reports, 1895, of neurotic individuals who acquired the power of creating by muscular action negative pressure in the œsophagus, and thus sucked air into the stomach. In the *Lancet* of August 1, 1896, Dr. G. A. Sutherland published a remarkable case of this kind. The power of swallowing air possessed by one of Barnum's "freaks," who could rapidly pass from the appearance of emaciation to corpulency, to which we referred in the *Lancet* of February 12, 1898, may also be mentioned. But if the air was really swallowed and not aspirated, the action is of a different kind, and is distinguished by Dr. Wyllie from air sucking.—*Lancet*.

The Immunisation of Sick Children with Behring's Serum (*Deutsche Med. Woch.*, 1898, Part 6).—Slawyk reports on the results achieved with Behring's antitoxic serum in the

immunisation of the children at the Charité at Berlin.

Since the beginning of 1895 all children admitted to the Charité Hospital have been immunised with 200 antitoxin units. The outbreaks of diphtheria, formerly periodical, have now ceased, owing, it is claimed, to the immunisation, which, however, the writer says, does not last longer than three weeks, and the children are, therefore, submitted to re-immunisation at the end of every three weeks as long as they remain in hospital.

When the injections were suspended, the outbreaks of diphtheria reappeared. When the injections were resumed, no new cases occurred. The injections were given to very young children, and to children suffering from severe febrile disease without the slightest ill effect.

The writer recommends a systematic immunisation of all children every three weeks in all instances where, as in the case of the Charité, it is impossible to prevent outbreaks of diphtheria in the wards.—*Treatment*.

Ascarides in the Bile-ducts.—Mertens (*Deutsche Med. Wochenschrift*, 1898, No. 23) reports a case in which the diagnosis was made during life. A woman, aged 30, who had had two attacks of biliary colic, was seized with colicky pain in the right side, with bilious vomiting, followed in a week by jaundice. On admission to the hospital the gall-bladder could be made out by percussion; it was not sensitive. The liver and spleen were enlarged. The symptoms grew worse; pleurisy, with effusion, developed on the right side; later, ascites and œdema of the legs appeared. The jaundice was intense, the stools were thin, with very little bile pigment and much free fat. Seven weeks after the beginning, after all the symptoms mentioned had become more pronounced, two ascarides were found in the stools. Both were macerated, and one of them showed a constriction about its middle. From that time the symptoms rapidly improved, though convalescence was delayed by a double suppurative parotitis. Mertens thinks that the entrance of the worm into the duct was assisted by dilatation of the common duct from the previous passage of gallstones. Out of forty-eight cases of round worm in the bile-ducts, there was a history of

gallstone in five only. The present case is the only one followed by recovery, if we exclude the one of Dunkel, in which a round worm was found in a liver-abscess. Besides these, only one other case is reported in which a diagnosis was made during life. A girl, aged 5, had jaundice, pain, enlargement of the liver, and repeated chills. Round worms were vomited and passed with the stools. Death occurred from multiple liver-abscesses. The necropsy revealed dilatation of the duct,—*American Jour. of Med. Sciences.*

Scarlatinal Myositis.—Brück (*Gazz. degli Ospedali*, July 7, 1898) has observed three cases of myositis in the course of scarlet fever in the second and third weeks after the subsidence of acute symptoms. This complication is unaccompanied by fever and, as a rule, disappears rapidly. From a clinical point of view it can hardly be distinguished from ordinary muscular rheumatism, and is characterised by spontaneous pain, extreme sensitiveness to pressure, and disturbance of motor function, with occasional increase in size of the muscles. The first was the case of a girl, aged 14, who noticed intense pain in the muscles of the back on the fifteenth day of the disease, rendering it quite impossible to sit up or turn in bed. The pains increased in severity for two or three days, but disappeared under salicylate of soda. In the second case the thoracic muscles were principally affected. In the third the abdominal muscles were so intensely tender to touch that it was impossible to make any examination.—*Brit. Med. Jour.*

Recurrent Idiopathic Pneumothorax without Effusion, ending in Recovery.—J. M. Finny (*Dublin Journal of Medical Science*). A stableman, aged 18, apparently quite healthy, was, while going to work, suddenly seized with violent pain in the chest. He returned home and went to bed. On admission to the hospital three days later, the left pleural cavity was found to be so full of air that the heart was pushed over to the right side. His respiration was easy (28); pulse, 96-100; temperature, 98°; and he felt quite comfortable. There was at no time any effusion into the pleural cavity. The air was gradually absorbed, and the patient left the hospital in about five weeks, having gained

half a stone in weight. A fortnight later he exerted himself in using a manure fork, and next morning his symptoms returned. When readmitted, the physical signs were the same as in the first attack, the heart again being pushed over to the right. He progressed favourably, but when last seen, nearly three months after the onset of the relapse, there appeared to be still some air in the upper part of the pleural cavity. The patient apparently did not suffer from phthisis.

The writer concludes—(1) That simple or idiopathic pneumothorax is a very rare disease of the lungs and pleura. (2) That a repetition of the disease in the same lung is of still greater rarity. (3) That in a very small number of cases the entrance of air into the pleura—to stretch it to its utmost limits—does occur without an effusion of fluid; and this even may happen a second time in the same lung. (4) That the absence of fluid renders the disease less fatal than when air and fluid are effused. (5) That the presence of air in the pleura may occur without any febrile or constitutional disturbance. (6) That the tendency of such cases is towards spontaneous recovery, and, in the absence of urgent symptoms calling for relief, it is wiser not to employ surgical means to let off the effused air.

Acute Pancreatitis.—E. S. Reynolds, M.D., F.R.C.P. (*Med. Chron.*, August, p. 328.) An hotel proprietor, aged twenty-nine, said to be temperate, had in May, 1897, an attack of pain in the epigastrium, followed by incessant vomiting, which lasted three or four days. In June, 1897, he had a more severe attack, but the pains were situated higher, over the cardiac region, and shot down the left arm; the heart's action was irregular. The attacks were thought to be due to angina pectoris. The patient was a heavy smoker. Another attack occurred in December, 1897, but the pain was more epigastric; it lasted four days, and was, like the previous ones, relieved by morphia and atropine. On February 6, 1898, whilst in good health, the pains in the epigastrium suddenly returned; they were very acute, and followed by vomiting. He was relieved by hypodermic injections, which were increased to $\frac{1}{5}$ grain morphia and $\frac{1}{45}$ grain atropine; but symptoms resembling those of atropine poisoning followed. The pupils were dilated and did not re-act to light; the

mouth, throat, and skin were dry; there was a scarlatinaform rash on the chest; the pulse was 120 and weak. He was delirious and had visual hallucinations. But the effect was greater than was to be expected from the dose, and he had had similar doses without these symptoms. He recovered from this condition. The abdomen was rather resistant, especially in the epigastrium, where it was somewhat prominent and tender on deep pressure. The symptoms resembling atropine poisoning recurred, and he died about sixty hours after the beginning of the attack. A necropsy showed a slightly enlarged cirrhotic liver and early interstitial nephritis. The pancreas was enlarged and hard, and there were gangrenous patches and recent hemorrhages, as well as dark pigment patches, probably due to old hemorrhages.

The delirium in this case is unusual in acute pancreatitis. The atropine apparently had nothing to do with the symptoms. The diagnosis of acute pancreatitis is very difficult; in fact, it is seldom made during life. The best guide is the rule given by Fitz:—"Acute pancreatitis is to be suspected when a previously healthy person, or a sufferer from occasional attacks of indigestion, is suddenly seized with violent pain in the epigastrium, followed by vomiting and collapse, and in the course of twenty-four hours by a circumscribed epigastric swelling, tympanitic or resistant with slight elevation of temperature."

Treatment is not satisfactory. Hot applications and morphia may be used for pain, stimulants and strychnine for collapse. If the acute stage passes off, but suppuration or gangrene follows, operation is necessary.

Noma in the Course of Pertussis.—Simonini (*La Pediatria*, November, 1897) records an instance of noma complicating pertussis, one of the rarest of the associations of cancrum oris. The patient was a girl of 3½ years. Towards the end of a severe attack of pertussis lasting three months, the parents noticed dribbling of saliva and detected a swelling of the gum over the right canine and premolar teeth. Two days later the disease had spread to the lip, the mucous membrane became livid and covered with grayish vesicles, which ulcerated; the teeth became loose and the breath fetid. The child was first seen on the twelfth day of the disease. The

right labial commissure was totally destroyed for an extent of two centimètres. Within the mouth the gangrenous lesion was more extensive; two teeth had been lost, the canine and premolar first involved; the mucous membrane was spongy, sanguinolent, and black; the frænum of the tongue was ulcerated. The temperature was 100·4 deg. Cure followed the use of the actual cautery and local antiseptic applications.—*American Jour. of Med. Sciences*,

The Comparative Etiology of Diphtheria.

—A series of observations recently collected by the French Conseil Supérieur d'Hygiène and quoted in the *Journal de Clinique et de Thérapeutique Infantiles* of September 22, 1898, show that the cat is especially liable to contract diphtheria and is a ready medium for its propagation. Other animals, however, are also liable. Thus Gerhardt relates the case of a number of fowls imported into a village, near Baden, which on arrival developed signs of a disease resembling diphtheria, half of them dying from it. Four cats living among them died from the same disease, and four out of six attendants at the poultry farm were infected. Another instance is mentioned by Dr. R. Jacobi: five children had diphtheria, and three kittens which had played with them during their illness died with false membrane in the pharynx. It is noteworthy that the bacillus of Klebs and Löffler cultivated by these observers in the rabbit has given rise to the usual signs of diphtheria including the subsequent paralysis, and that the observations of Klein on the cat have confirmed their results. These facts may explain the occurrence of sporadic cases of diphtheria for which no cause can be found, but where a sick rabbit or cat has been nursed for a time before the child's illness appeared. It would seem also that in some cases a connection exists between the yards or kennels in which animals are housed and the occurrence of tonsillar sore-throat in adjacent dwellings.—*Lancet*.

Pneumonia is now recognised to be produced by many different bacteria, even when lobar in type, and the difficulties of treatment are increased by our inability to distinguish clinically its varieties and their causes. Thus J. W. Moore recognises, besides those forms due to the dip-

lococcus and the bacillus of Friedländer, special types found in erysipelas, influenza, tuberculosis, and typhoid, as well as those due to actinomycosis, aspergilli, diphtheria, and, we may add, to the organisms of acute rheumatism and small-pox. Besides ordinary septic pneumonia complicating erysipelas, Moore has observed, in migratory pneumonia, patches of erysipelas on the skin, which altered their position as the area of consolidation in the lungs changed. The exciting organism here seems to be a streptococcus; in influenzal pneumonia, besides Pfeiffer's bacillus, a similar growth, has been often discovered. A true pneumonia, due to the tubercle bacillus, occurs in cases of acute phthisis in young persons, while in typhoid, besides the frequent occurrence of septic and diplococcic pneumonia, during the depression due to typhoid poison, we find some evidence of occasional pneumonias produced by Eberth's bacillus itself. Generally speaking, the coccus of Friedländer is less virulent than the diplococcus of Fränkel, a delicate organism which soon dies out.

Dürck finds that any of these germs may be present in actually healthy lungs, and that if blown down a tracheal tube they are incapable of causing the disease. If, however, dust is injected, or the animals are first kept warm and then immersed in a cold bath, lobar pneumonia frequently follows such an insufflation. Recent research, too, has shown the presence of the diplococcus not only in the mouths of a few persons, but almost universally. In pneumonia, under favourable conditions, this organism not only multiplies in the lung-cells but gains entrance to the blood and produces a true septicæmia. Thus Kohn found it in the blood in nine cases out of thirty-two, and it is noticeable that seven of these were the only fatal ones of the series. Little reliance has hitherto been placed on the various forms of serum proposed for pneumonia. This is not surprising if the difficulty of diagnosing the active agent in the disease, the possible existence of a depressing cause, such as the toxin of typhoid, which keeps open the gate for fresh infection is considered. Still, good results have been obtained in many cases. Washbourn immunised a horse for nine months and obtained a fairly powerful serum, capable of neutralising highly fatal doses of bacilli. Its protective power in

early stages of the disease seems definite, but its bactericidal effects *in vitro* are uncertain and its antitoxic effects are unknown.—*Bristol Med. Jour.*

Typhoid Fever; Tympanites: Death averted by Puncture of the Transverse Colon.

—Dr. J. W. Dalgleish (*Lancet*, Oct. 1, p. 871). A man, aged 30, the subject of severe typhoid fever, had extreme tympanites displacing the heart and interfering with its action. The apex beat was well above and to the left of the left nipple; the pulse was small, frequent, and irregular; the countenance was drawn, haggard, and pinched. Turpentine by the mouth was useless, the passage of a long rectal-tube led to the evacuation in large quantity of typical "peasoup" fluid extremely offensive, but no relief was obtained. The transverse colon was clearly delineated, running across the abdomen very distended. A Southey's trochar and canula were pushed into it; much gas escaped with a loud hissing noise for two minutes. The abdominal distention was greatly relieved, the facial expression improved wonderfully, the pulse became less frequent, regular, and stronger. The patient eventually recovered.

Two cases of Carcinoma of the Stomach with Perforation of the Anterior Abdominal Wall.

—Winterberg (*Wiener Klinische Rundschau*, September, p. 585). The rarity of perforation of the abdominal wall, and resulting gastric fistula in cases of cancer, is shown by the fact that Murchison, writing in 1858, could only collect six such cases, while Lange (Inaug. Diss., Berlin, 1877) found only one such instance among 210 cases, and Brinton one in 507. Mislowitzer (Inaug. Diss. 1889) collected sixteen cases and added one of his own. Dr. Winterberg's first case was a man of 23 years, with a history of pain in the stomach and vomiting of a year's duration. His mother had died of cancer of the stomach. The patient had been rapidly losing flesh and was much emaciated on admission to hospital. A hard tumour was palpable in the epigastrium apparently attached to the stomach, and an exploratory laparotomy showed that the whole anterior wall of the stomach was infiltrated with cancer. Three months later the growth made its way through the scar of the operation wound, and a gastric fistula resulted;

the patient only survived this occurrence twenty-four hours. At the autopsy the growth was found to have originated in the pancreas. The second patient was a woman of 69 with the usual symptoms of gastric carcinoma. Operative interference was declined by the patient. She was awakened one night in her sleep by a sensation of hot fluid running over the abdomen, and this was found to be due to the escape of gastric contents through a fistula, situated two fingers' breadth to the left of the navel. Its edges were raised, and resembled everted mucous membrane; a portion was excised and proved to be medullary carcinoma. Fluid exuded from the opening both spontaneously and on pressure, but no free hydrochloric acid was found in it. The stagnation of food in the stomach was proved by the fact that charcoal administered by the mouth was found to be passed through the fistula as much as two days afterwards. The patient lived five months after the perforation. An account of the cases previously reported is appended to Dr. Winterberg's article.

A New Method of Cystorrhaphy.—Juvara and Balacescu (*Wiener Klinische Rundschau*, October, p. 653) suggest, as the result of experiments upon dogs, the following method of closing wounds in the bladder. The mucous membrane is separated along one side of the wound from the muscular wall and a portion of the former is cut away. The cut edge of the mucosa thus left is united to the corresponding edge of the mucosa at the opposite side of the wound and the flap of muscular tissue which is now left, overlapping the line of the sutured mucous membrane, is united by three rows of sutures to the outer surface of the muscular tissue on which it lies. In this way a roof is provided, which covers in the wound in the mucous membrane and prevents the possibility of leakage. The article is illustrated by diagrams.

Marmorek's Anti-Streptococcus Serum.—Dr. Bonne (*Therapeutische Monatshefte*, Sept., p. 498.) accidentally inoculated himself in the foot with pyogenic matter from a boil which he had incised in a patient. Lymphangitis resulted and a state of chronic pyæmic infection was set up with the formation of metastatic abscesses. Finally an attack of breathlessness suddenly occurred, attri-

buted to septic embolism of the lungs. The serum was then injected, over five weeks after the commencement of the illness, and its effects were prompt and remarkable. Pain subsided, fever diminished, and the patient was himself conscious of a feeling of great relief and improvement. Further symptoms however occurred, needing a repetition of the treatment, with equally good results. At the end of fifty-six days the temperature was normal; convalescence was uninterrupted. Dr. Bonne attributes his recovery entirely to the serum.

Tuberculosis of the Stomach.—The number of well-authenticated cases are comparatively few, though it is seen in guinea-pigs the subject of experimental tuberculosis. The frequency of tuberculous ulcers in the stomach was formerly exaggerated, because ulcers in tuberculous patients were regarded as of necessity of this nature. Blumer (*Albany Medical Annals*, March, 1890) has collected thirty cases, all secondary, of tuberculous disease of the stomach. They may be divided into (1) miliary tuberculosis of the stomach, (2) single, and (3) multiple ulcers.—*Practitioner*.

Myxœdema.—Korczynski (*Wiener Medizinische Presse*, No. 36, p. 1418) records some clinical observations on a case of Myxœdema, which, of itself, presented no special feature of interest. The stomach contents exhibited a considerable quantity of mucus, with deficiency of hydrochloric acid and of motor power in the muscular coat. The urine contained some albumen and a diminished amount of chlorides along with hyaline casts, leucocytes, and epithelium. Examination of the fæces showed the presence of undigested muscle fibres along with mucus and other signs of catarrh of the bowel. The blood showed some degree of anæmia, a small number of poikilocytes and microcytes, and a number of eosinophile cells. Treatment, with thyroid gland caused loss of weight, increased quantity of hydrochloric acid in the gastric juice, and improvement in the condition of the blood. Menstruation, which had previously ceased, was again established, and the condition of the urine also became normal. The author considers that the condition of the urine was the result of irritation of the kidney produced by accumulation of

albuminous substance in the blood, owing to faulty metabolism. Difficulty in the diagnosis of myxœdema may arise if the symptoms are localised. The writer alludes to two such cases which came under his observation, in one of which the abdomen, in the other the neck and chin, were principally affected.

Beri-Beri in Temperate Climates.—Dr. C. Norman (*Brit. Med. Jour.*, Sept. 24). In temperate climates beri-beri has been chiefly observed in lascar sailors, or in Europeans just returned from the tropics. But in 1894 the writer observed an epidemic among the insane poor in the Richmond Asylum, Dublin; again in 1896, and again in 1897. The first condition noticed was usually œdema over the front of the tibia. There were cramps in the calves, and itching or numbness. Of the motor symptoms the first and most remarkable was loss of power in the peroneal muscles and in the flexors of the foot; in a small number of cases the muscles of the forearm and arm were tender and weakened. Cutaneous anæsthesia and paræsthesia were present. He noticed a phenomenon not before described—the existence of a zone of very distinct hyperæsthesia around each zone of hypoæsthesia. A few cases were tested for anæsthesia of the pharynx, and it was always found. Œdema was a constant symptom. The length of an attack was uncertain, death occurred in a variety of ways: from œdema of the lungs, degeneration of the heart, or paralysis of the respiratory muscles.

As to the etiology of these strange epidemics, Dr. Norman states that there is no reason to believe that the disease was personally imported, but he fails to put forward any satisfactory view.

Ulcerative Orchitis Following Typhoid Fever.—Dr. A. Breton, of Dijon (*Journal des Praticiens*, Sept. 3), relates the case of a lad seventeen years old, who was attacked with typhoid fever late in July, 1897, and became convalescent toward the close of August. At that time, however, he was seized with severe fever and testicular pain, and suppuration rapidly followed. On October 26 he came under Dr. Breton's observation. There was an ulcer on the right side of the scrotum about as large as a franc piece, and by the side of it there was a very small opening of a

sinus. The surrounding skin was violaceous, and the general aspect of the lesion was that of a tuberculous ulcer. He did not re-act to an injection of tuberculin. The parenchyma of the testicle was involved, but the epididymis and the spermatic cord were healthy, and there was no effusion into the tunica vaginalis. The lymphatic glands of the right groin were enlarged. The diseased portion of the testicle was excised. The remainder of the gland was perfectly healthy. The wound healed in a week, and the cure was complete. There were no tubercle bacilli in the excised tissue, but there were a few bacilli which the author is inclined to look upon as those of Eberth, although the examination did not determine positively that they were not specimens of the *Bacillus coli communis*.—*New York Med. Jour.*

Dysenteric Arthritis.—Dr. Paul Remlinger (*Revue de Médecine*, Sept., p. 685) records two cases. Both patients were men without any known rheumatic tendencies, and were attacked during convalescence from well-marked dysentery. One had inflammation of the right knee, characterised by the great abundance of the effusion; later, the left ankle was involved. The joint affection in the other was shown at first almost exclusively by pain, especially on movement, affecting successively the right wrist, the right acromio-clavicular joint, the left and right ankles. A few days later the knees were involved, but here the arthritis produced considerable effusion. Both patients completely recovered in a few weeks. Aspiration of the knees revealed a serous fluid, which was found to be sterile.

All the ordinary methods of treatment—immobilisation, counter-irritation, compression—appeared of little use, but aspiration seemed to be very beneficial. The writer has only been able to find one other example of dysenteric arthritis treated by aspiration in medical literature.

The Surgical Treatment of Portal Obstruction.—Talma of Utrecht (*Berliner Klin. Wochenschrift*, September 19, 1898) calls attention to those cases of cirrhosis of the liver, where the only symptoms of the disease is ascites, which may be the actual cause of death, the function of the liver cells being unaffected. In these cases improvement or cure can take place if a collateral

circulation develops, and Professor Talma proposes to establish the circulation required for the blood in the vena portæ by operation. This has been successfully carried out in one of his cases. A boy, aged 9, had a severe acute hæmorrhagic nephritis, and a disease of the liver which ended in atrophic cirrhosis and obstruction to the portal circulation. The cause of the disease was unknown. That the ascites was not secondary to Bright's disease, as the œdema in other parts of the body, but to a retardation of the portal circulation, was proved (1) by the ascites persisting after the anasarca had vanished, and (2) by the ascites quickly returning after repeated paracentesis, and even incision of the abdominal wall. On March 7, the great omentum was sown into an abdominal incision, and the gall-bladder was sutured to the parietes. After the operation an active collateral circulation was rapidly established from the portal system to the intercostal veins. The ascites disappeared. The spleen, however, which had always been enlarged, increased in size steadily till it reached Poupart's ligament. On July 2, it was sutured in between the abdominal muscles and the skin. From that date it decreased in size, and large superficial veins carried off part of the splenic blood. Complete recovery followed. Two years later the superficial collateral veins were still large. The boy was in perfect health. There was no ascites, though the liver was hard and somewhat enlarged. The spleen reached $2\frac{3}{4}$ in. below the ribs. The urine and fæces were normal. A difficulty in the general application of this principle is that cases suitable for operation are often very hard to diagnose.

Constant Presence of the Pneumococcus on the Surface of the Tonsil.—The pneumococcus may be found in the mouth as a simple saprophyte in healthy subjects. M. Wetter has shown that the inoculation in mice of the saliva of individuals who had not been subjects of pneumonia caused pneumococcic septicæmia in twenty per cent. of the experiments. He found the saliva of those who had suffered from pneumonia more virulent; in four-fifths of the experiments septicæmia was produced. At the meeting of the Société des Hôpitaux of April 15, MM. Benzançon and Griffon showed by culture methods that the pneumococcus was present not frequently but constantly in the mouth. They had found

that the serum of young rabbits aged about two months was a favourable medium for the cultivation of pneumococci. Mucus removed from the surface of the tonsil of forty individuals of all ages, some healthy and others suffering from various complaints, invariably yielded on this medium cultures of pneumococci. An important practical conclusion follows from this discovery. It is not sufficient to successfully inoculate the saliva or to make cultures from it to prove the presence of a pneumococcic affection. The expectoration or exudation must be directly examined and the presence of a large number of encapsulated diplococci which colour by Gram's method be proved.—*Lancet*.

Paralysis of the Serratus Magnus following Influenza.—Von Rad (*Münchener Med. Wochenschrift*, September 6, 1898) publishes a case of paralysis of the serratus magnus, which set in within a week of the onset of influenza, and led to a rapid reaction of degeneration. The case is interesting as being the second reported after influenza, and also because it was an example of simple serratus paralysis, none of the other shoulder muscles being affected. This is quite the exception, as some other muscle, generally the trapezius, is paralysed as a rule.

Congenital Laryngeal Stridor.—Stamm (*Münchener Med. Wochenschrift*, September 20, 1898) describes a case of congenital laryngeal stridor, a disease not usually mentioned in the text-books. It differs from ordinary laryngismus stridulus in the following respects:—(1) Congenital stridor is present at birth, or appears shortly afterwards; laryngismus never before the third month, and almost always at the period of dentition. (2) Laryngismus generally occurs in sickly children; congenital stridor has no connection with rickets or with infantile tetany. (3) Laryngismus occurs in paroxysms, with cyanosis or even convulsions; congenital stridor accompanies each inspiration for weeks or months without cyanosis, and usually without general convulsions. (4) Unlike laryngismus, there is no arrest of respiration after the whistling inspiration, and expiration is perfectly free. (5) Attacks of laryngismus are often brought on by crying, which relieves or abolishes the dyspnoea of congenital stridor. (6) Laryngismus, though often beginning

immediately on waking, does not occur during sleep, when the inspiratory congenital stridor is most marked. The writer believes that congenital stridor is of central nervous origin, though recently Avellis and others have maintained it to be due to an enlarged thymus. The prognosis is good, unless general convulsions set in; and this is very rare. The symptoms generally disappear gradually in the course of a few weeks or months, though they may continue into the second year of life. Treatment consists in giving phosphorus with cod liver oil.

Thrombosis of the Vena Cava Inferior.—

J. Bugge (*Norsk. Mag. f. Lægevidensk.*, July, 1898) records the case of a sailor, 42 years of age, who fell, from a height of 6 mètres, in the hold of a ship. The accident was followed by sharp pain and by paræsthesia in the lower limbs. Sensibility and movement were markedly diminished. A month later oedema and varicose veins appeared in the legs, and a year and a half later the veins of the abdominal walls became dilated and sinuous. These veins were specially evident at the sides of the abdomen, had the thickness of the finger, and represented the hypertrophied circumflex iliac veins. The current of blood in them was from below upwards. The inferior epigastric veins were also enlarged, but the circumumbilical veins nor the truncus anastomoticus lumbo-vertebralis were not.—*Brit. Med. Jour.*

Vascular Occlusion a Cause of Symptoms of Intestinal Obstruction.—

In a woman, aged forty-five, the subject of tertiary syphilis, sudden onset of symptoms suggesting internal strangulation were found to depend on hæmorrhagic infarction of the small intestine, and a successful result followed resection of 2 ft. of the bowel. Dr. T. E. Gordon (*Brit. Med. Journal*, 1898, vol. i., p. 1447) suggests that the infarction was due to thrombosis set up by syphilitic endarteritis of the mesenteric artery, and that strangulation of the bowel necessitating a successful herniotomy some nine months previously determined the locality of this lesion. It is noteworthy that while thrombosis or embolism of the mesenteric artery rapidly gives rise to symptoms of intestinal obstruction, the same lesion in the mesenteric veins is followed by the slow development of similar

symptoms. Dr. J. Rose Bradford's (*Brit. Med. Journal*, 1898, vol. i., p. 1136) case of thrombosis of the superior mesenteric vein causing intestinal obstruction illustrates this.

Yellow Palms as a Sign of Typhoid Fever.—

Filopowicz (*Centralblatt für die Med. Wiss.*, 1898, No. 11) calls attention, for the second time, to a symptom of typhoid fever not generally recognised. The palms and soles acquire a yellow colour, which is more marked in proportion as the skin is thickened by toil, but is present even when the skin is thin. This change comes on in the early days of the disease, and lasts until the end, disappearing in convalescence. The writer thinks the sign is due to the changes in the circulation, especially to anæmia of the skin, which causes the subcutaneous fat to show through.—*Amer. Jour. of Med. Sciences.*

Typhoid Fever and Infected Ice.—

An outbreak of typhoid fever among the junior officers of a French regiment stationed at Rennes is attributed by Dr. Dorange (*Revue d'Hygiène*, April, 1898) to the use of ice obtained from the Vilaine at a point below the town, where the water was extensively polluted by the sewage of a large district in which there had been a number of cases of typhoid fever. All the regimental officers had been present at a dinner, where the food being the same for all, the beverages consumed differed in this respect, that the captains and other superior officers drank only beer, while the lieutenants, who were in a room by themselves, drank champagne-cup. It was only among the latter that the cases, eight in number, appeared. It was discovered that the ice used in making the cup came from the source mentioned.—*Amer. Jour. of Med. Science.*

The Length of the Incubation Stage in Typhoid Fever.—

E. Jancken (*Wiener klinische Wochenschrift*, 1898, No. 27) had an opportunity of making an important observation. Certain troops marching through two small villages in which were a number of cases of typhoid fever, drank copiously of water. That infection was acquired in this way follows from the absence of other exposure. Moreover, other troops passing through without pausing to drink remained free

from infection. Of the thirty-six cases the symptoms appeared suddenly in all, with headache, chill, fever, severe diarrhoea, abdominal pain, and weakness. The course was mild, and defervescence occurred in the third week. The beginning of the disease was noted in three men on the second day (*i.e.*, two days after infection), in seven on the third day, in six on the fourth, four on the sixth, five on the seventh, in the other seven between the ninth and fourteenth days. This shows that under favourable conditions the typhoid bacilli can produce symptoms within two days. In the cases observed the favourable conditions consisted in great fatigue, excessive thirst, and the ingestion of considerable quantities of the infected water. That the germs were not of unusually great virulence may be inferred from the mild form of the disease.—*Amer. Jour. of Med. Sciences.*

Rectal Examination in Abdominal Disease in Children.—Dr. George Carpenter, (*The Lancet*, September 27, p. 789), calls attention to this useful but neglected method. In a case of obstinate constipation in a little girl assiduously treated by drugs, rectal examination revealed a tumour growing from the sacrum which proved to be myeloid sarcoma. Small cysts of the ovary, displacements of the ovary and tubes into the inguinal and crural openings, pyosalpinx, tuberculosis of the genital organs, may be detected in this way.

The Etiology of Tetanus.—Bandisch (*Berliner Klin. Wochenschrift*, August 1st, 1898) relates the case of a gardener who suffered from carious teeth, and had the habit of picking them with a splinter of wood, and further, when he had the toothache, of poking the splinter about in the cavity until the gums bled, by which means the pain was said to be relieved. After doing this one day while his hands were covered with garden earth, trismus set in and was followed in about a week by opisthotonos, difficulty in swallowing, hyperaesthesia, increased reflexes, and clonic spasms in the leg, in short all the symptoms of a mild attack of tetanus. There was nothing pathological to be found in the gums near the carious tooth in question; the tooth was extracted under chloroform. The symptoms began to improve on the following day, but it was nearly

three weeks before the trismus and clonic spasms in the legs had quite subsided. The tetanus bacillus is commonly found in garden earth and manure, and hence the patient's occupation is of interest, as well as the peculiar method of infection.

Intra-Uterine Typhoid.—Fordyce (*Scottish Medical and Surgical Journal*, 1898, vol. iii., No. 1) reports a very interesting case in which typhoid was demonstrated in a five-months' foetus. The mother aborted and died soon after.

Externally and internally nothing abnormal could be seen by the naked eye in the foetus or its appendages. There was a small quantity of serous fluid in the abdomen. The intestines seemed quite healthy; the liver and spleen were not enlarged. Tubes inoculated from the kidney, spleen, and intestinal contents gave pure cultures of the typhoid bacillus; the blood was sterile. Care was taken to make tests, which showed the absence of the bacillus coli communis. It was impossible to demonstrate bacilli in the tissues by microscopic examination. The Widal test was very successful in this case.

Fatal Sulphonal Poisoning. Loien (*Berliner Klin. Wochenschrift*, September 26, 1898), reports a fatal case of sulphonal poisoning. A married woman, aged 32, was being treated for an attack of mania. Fifteen to thirty grains of sulphonal were given in the course of a day in divided doses, and this treatment was continued from July 6 to August 21, though with frequent interruptions. Each dose was given in plenty of liquid. After August 21 no more was given as the patient was quieter. One and a-half days later the symptoms of poisoning set in with abdominal pain and constant vomiting, which ceased after four doses of cerium oxalate. Shortly after the onset of vomiting there was observed the characteristic paralysis, which is doubtless a peripheral neuritis. Beginning in the legs, it then reached the arms, and finally affected speech and swallowing. The following are the special points of interest in the case. (1) The symptoms of poisoning were delayed till after the last dose had been given. Delayed absorption could hardly account for this, considering the mode of its administration. (2) The urine was perfectly normal until eight days after the onset of the symptoms, when there were albumin and

hæmatoporphyria. Now the discolouration due to the latter is generally supposed to be an early, if not the earliest, sign of poisoning. (3) There was no diarrhoea. (4) The morbid anatomy showed, among other things, typical toxic nephritis, and extreme degenerative changes in the muscular wall of the heart. Sulphonal is a dangerous and insidious poison, and according to Wien, should be given as little as possible, and then with long intervals of abstention. The mortality from its use is probably higher than from chloroform anaesthesia, and yet it is often given in much less urgent cases. The treatment of poisoning consists of stimulation by alcohol and hypodermic injections of camphor. Probably transfusion, or failing that, the injection of normal saline solution, would do good.

Eruption due to Exalgine.—Linossier (*Journal de Pharm. et de Chim.*, No. 8, p. 413, 1898).—The patient was an arthritic and hysteric woman, 35 years of age, affected with biliary calculus, and presenting in the urine neither sugar nor albumin. Antipyrin having always produced in this case characteristic eruptions, she one day took instead, for the mitigation of an attack of migraine, a cachet containing 0.25 gramme (4 grains) of exalgine. This solitary dose in a short time produced upon the skin and the mucous membrane of the anus and vagina a general papulose eruption, with patches of a fiery red colour, and, in certain spots, large blisters, containing a clear serous fluid. The rash, which lasted four days, caused pain when pressure was applied, but it was not pruriginous. In the course of the discussion upon M. Linossier's note, M. Bardet remarked that the doses of exalgine, as set forth in the various formularies, are too high. He considered that the maximum dose for twenty-four hours should be—for a man, 0.25 gramme (4 grains), and for a woman, 0.15 gramme (2½ grains).—*Med. Chronicle*.

Lateral Curvature of the Spine.—Haudek (*Wiener Klinische Rundschau*, Nos. 37, 38, 39). With regard to scoliosis, prevention is of the greatest importance. All the rules of the hygiene of infancy should be carefully observed. Children

must not be allowed to sit up too early, nor must they be carried continually on one arm. Later, during the school period, careful medical supervision is necessary. Great care should be taken that the desks at which children write are of proper height and slope, that they have a proper foot-rest and seat, and that the light falls in the proper direction. If any tendency to spinal curvature is detected prompt treatment must be adopted and the dangerous fallacy avoided that the child will "grow out of" any such defect. If the condition has already developed, general treatment must be adopted by means of gymnastics, Zander's apparatus, and drill; but here, again, strict medical supervision is needed, or harm may be done instead of good. Manual correction of the deformity may be practised in some cases, in others apparatus is necessary. A good application for slight cases of lumbar scoliosis is Volkmann's slanting seat. Suspension may be practised either vertically or on an inclined plane, on which the deformities are corrected by padded cushions. Finally, there is the plaster jacket; or, better, Hessing's "corset," in which steel springs are used as supports. There is no danger of any weakening or atrophy of the muscles resulting. If the child is obliged to attend school, exposed to all the evils from which the deformity originally arose, some such artificial aid to correct carriage is necessary, as mere instructions as to posture are soon forgotten, even if they are fully understood at the time. Prognosis is worst in cases occurring very early, and in those arising after puberty. Deformities with large curves respond better to treatment than those with sharp angles involving fewer vertebrae. Cases resulting from anaemia or rickets seldom do well.

The Antiquity of Syphilis.—This interesting question has been investigated by Dr. Zambaco-Pacha (*La France Médicale*, December 24, 1897). The supposition that syphilis was introduced into Europe in the fifteenth century by Christopher Columbus from America was due to the epidemic at Naples appearing about the same time as his return. There is, however, considerable evidence that syphilis dates as far back as history goes. Ricord is said to have remarked: "Au commencement Dieu créa le ciel, la terre, l'homme et les maladies vénériennes"

Dabry, French Consul at Han-Kiou, showed that the Chinese treated syphilis with mercury 3,216 years before our time (*La Médecin chez les Chinois*, 1863), and Scheube finds syphilis described in a Japanese treatise on medicine written 808 years B.C. (*Archiv. de Virchow*, 1883).

In Biblical times we find evidence of what was probably syphilis. In the year 1451 B.C. Moses, in order to stop contamination, killed 24,000 Hebrews who had had connection with infected Moabite girls, and strangled all the women. The disease of Baal Peor, which infected the camp of Moses, was very contagious, and was transmitted to all the members of one family, according to the historian Joseph. This disease was probably syphilis according to Hamonic (*Des Maladies vénériennes chez les Hébreux à l'Epoque biblique*). The latter writer maintains that Sarah gave syphilis, contracted from her husband, to Pharaoh, also to the King of Gerar named Abimelech. In the proverbs of Solomon we find: "Remove thy way far from her, and come not nigh the door of her house, lest thou give thine honour unto others and thy years unto the cruel—and thou mourn at the last when thy flesh and thy body are consumed."

There is considerable evidence that syphilis was known among the Greeks and Romans. Hippocrates describes symptoms apparently due to syphilis, viz., ulcers on the mouth and genitals, eruptions, affections of bones, nails, and hairs, and "carnosities." It has even been maintained that the plague of Athens was of venereal origin.

Thucydides describes disease of the genitals apparently identical with chancre.

Dioscorides, physician to Cleopatra (first century B.C.), mentions condylomata, papules, and rhagades, and proposes mercurial treatment; and Martial in the same century relates the case of a whole family affected apparently by syphilis.

Pliny mentions that a woman having seen an ulcer on her husband's penis, and believing herself infected, threw herself with him into the lake.

The knights of the eleventh and thirteenth centuries, an agglomeration of depraved and debauched men, brought on a terrible revival of the disease, such as the epidemic at Naples.

In Egypt the disease was spread by the worship of Phallus, and by the relations with Syria and Chaldea, where venereal disease was rife. On

Assyrian tablets found at Babylon it was deciphered that Istar, the goddess of criminal love, demanded to marry Izdubar, and on the latter declining, the goddess's father sent a sacred bull against Izdubar. In the struggle a friend of Izdubar tore off the bull's penis, and threw it at the figure of the goddess. He was then struck with disease, and his body covered with pustules and scabs.

So much for mythological and early historical evidence. Now for more recent facts. In the winter of 1896 Zambaco-Pacha sought for evidence of syphilis among the bones of the ancient necropolis at Cairo. Several bones showing evidence of rickets and Pott's disease were found. Also a skull with perforation of the outer table of the parietal bone, loss of a sequestrum, and reparatory processes round the edges. In the same skull were other similar lesions above the nasal bones and near the orbit. All these lesions had the appearance of tertiary syphilis.

In the necropolis of Abydos, Tonquet found a skeleton with syphilitic lesions of bone, including periostitis and nodes of the tibia. Other bones presented exostoses, and condensing and rarefying osteitis. This dates back to the time of the Pharaohs.

In a skull from the ancient leprosy hospital of Montpellier, the parietal bones were affected with caries evidently due to syphilis. Hence leprosy was confounded with syphilis in those days, and the two diseases co-existed.

Broca and Lancereaux also found syphilitic bones in leprosy cemeteries; and in the anatomical museum at Geneva there are syphilitic bones from an old leprosy cemetery.

Ducrot in 1872 discovered at Solutré a female skeleton said to belong to the period of primitive man. The tibiae of this skeleton presented exostoses, recognised as syphilitic by Virchow, Broca, and Ollier. Also in the Institute of Anthropology there are syphilitic bones found in Peru. Hence syphilis was present in Peru before the discovery of America. Further, Dr. Thulie, at the Anthropological Society of Paris, showed a prehistoric skull of an Indian of Pernambuco with typical syphilitic lesions.

Parrot considers that syphilis must be considered the oldest disease of the human race, since it existed in the quaternary period.—*Treatment.*

Portal Thrombosis with Symptoms of Intestinal Obstruction.—Portal thrombosis is difficult of diagnosis, the symptoms being usually like those of cirrhosis of the liver, of which, indeed, it is often only a complication. The following case—in which they were acute and of a very different type, resembling at first those of biliary colic and then those of acute intestinal obstruction—is exceptional. It is published by Dr. Barth in the "Proceedings of the Société Médicale des Médicales des Hôpitaux" of October 28, 1897. A robust man, aged 47 years, of intemperate habits, was suddenly seized with violent epigastric pain and vomiting. The symptoms recurred in crises lasting several hours every day, which yielded only momentarily to morphine. Examination showed slight tenderness in the epigastric and right hypochondriac regions. The bowels acted regularly. Suddenly, on the seventeenth day, a change took place. The abdomen became tympanitic, hiccough and abundant vomiting of green porraceous matter occurred, the patient became feverish, and his expression altered. On the next day the temperature was 104.5° F., the pulse 140 and thready, and the vomiting continual; the abdomen was uniformly distended tight and very tender; the eyes were sunken, the voice was broken, and the expression was hippocratic. There had been no passage of fæces or flatus for twenty-four hours. Internal strangulation complicated by acute peritonitis was diagnosed, and laparotomy was proposed; but the patient became rapidly weaker and died in a state of collapse. A necropsy was made. The abdomen contained some reddish serum. The intestines were uniformly distended, and the peritoneum was injected, of a bright red colour, but without exudation, except at a loop about the middle of the jejunum, which was purple, almost blackish, like a strangulated intestine, and covered with false membranes. The mesenteric veins, not only of the diseased, but of the healthy, intestine were thrombosed throughout. In the portal vein thrombosis was more marked, the clot was greyish-red, firm, elastic, and manifestly older than the mesenteric. The thrombosis was not prolonged into the intra-hepatic divisions. The liver was diminished in volume and flabby; it was not cirrhotic or otherwise diseased. The question arises—Was the thrombosis the cause of the intestinal lesions, or were the latter

the primary? Might there not have been a temporary strangulation of the intestine which caused incipient gangrene, then mesenteric thrombosis, and, finally, peritonitis by permitting migration of colon bacilli through the disorganised intestine? To this view there are several objections. No trace of constriction or mesenteric torsion was found. Above the diseased loop were analogous lesions less advanced and becoming slighter from below up. The intestinal lesions were too recent to explain the preliminary symptoms. Finally, the portal thrombosis was evidently much older than the mesenteric. Again, why was there gangrene of only a limited portion of intestine from this generalised portal thrombosis? Dr. Barth cites a number of such cases in which the thrombosis extended to the whole length of the intestine, in which only a limited lesion—cyanosis with sanguineous infiltration or gangrene, was found. In all the symptoms simulated acute obstruction and a similar part was affected—near the middle of the jejunum. He suggests an anatomical explanation—probably there is complete absence of anastomotic communications in this part which is situated in the centre of the mesenteric system, but above and below some collateral circulation by means of parietal veins is possible. In the Transactions of the Pathological Society of 1876, page 124, the late Dr. Hilton Fagge published a very similar case to Dr. Barth's, in which even the same doubt as to intestinal strangulation arose at the necropsy. But as a type, pathological and clinical, this condition has not been described.—*Lancet*.

Morphine Poisoning in an Infant.—J. Fotheringham, M.B. (*Brit. Med. Jour.*, Oct 22, p. 1251).—A solution of hydrochlorate of morphia B.P. was supplied by a druggist in mistake for fluid magnesia. A teaspoonful (which was found to contain 75 minims) of this was given to an infant aged three months. About ten minutes afterwards the child was suddenly seized with convulsions. When seen about an hour afterwards, the child was suffering from violent tetanic convulsions with periods of cessation of breathing. As the pupils had the characteristic pin-point contraction opium poisoning was suspected. What was left in the bottle, too, had an acetous smell and the taste of morphine. As the child was comatose

the administration of an emetic was impossible, and the convulsions made the use of the stomach pump equally so. Artificial respiration was performed, and had to be kept up constantly for three, and occasionally for the succeeding six or seven, hours. On several occasions it was feared the child was dead, but the heart sounds could be heard faintly as the artificial respiration was continued. At first the pulse was unnaturally strong.

Within an hour after the child was seen $\frac{1}{300}$ grain of atropine was injected subcutaneously, and as there was no impression on the pupil in half an hour $\frac{1}{150}$ grain was used. The pupils then lost some of their contraction and the spasms were less intense. Twice afterwards $\frac{1}{300}$ grain was administered. About an ounce of strong decoction of coffee was given by the rectum, at first every half hour and latterly, alternately with the same quantity of peptonised milk, every hour. Fomentations were applied over the epigastrium. The face, upper part of chest, and other parts were slapped with a cold wet towel. It was twenty-four hours before the child opened its eyes, and even then in a very languid manner. Then it swallowed a little, but it was nearly forty-eight hours before it would suckle.

The temperature then began to rise. This was ascribed to reaction from the shock, but later evidence of right broncho-pneumonia was found. The temperature reached 104 deg. F. At the end of ten days the child was quite well.

A Pathological Plantar Reflex.—M. Babinski (*Semaine Médicale*, July 27, 1898) writes on a peculiar modification of the plantar reflex, termed by him "the phenomenon of the toes," which he first described in 1896. In the normal plantar reflex, besides other movements, flexion of the toes on the metatarsus occurs. In some healthy individuals the toes remain, apparently immobile, but they never execute extension movements. In certain diseases, on the contrary, a movement of extension, especially of the great toe, takes place. This modification of the plantar reflex M. Babinski terms "the phenomenon of the toes." It may occur in lesser degrees—that is to say, the reflex may be partly physiological, partly pathological: there may be extension of the great toe, or of the two first toes and flexion of the others, or stimulation of the external part of the

sole may cause extension of the toes and stimulation of the internal part of the sole may cause flexion, or stimulation of any part of the sole may produce sometimes extension, sometimes flexion. This inversion of the normal plantar reflex is found in a variety of diseases; in hemiplegia from any organic disease of the brain (on the paralysed side), in paraplegia, in hemiparaplegia (on the paralysed side), in Friederich's disease, in diffuse meningo-encephalitis in cerebro-spinal meningitis and in strychnine poisoning, in Jacksonian epilepsy (on the affected side immediately after a crisis). It occurs not only in old cases of hemiplegia with rigidity, but also immediately after the onset of hemiplegia with muscular flaccidity. Similarly, in spinal cases, it occurs in spastic paralysis from any cause, and in recent paralysis from injury of the cord with flaccidity of the muscles and diminution or abolition of the tendon reflexes. On the other hand, the phenomenon was not found in hysteria, uncomplicated tabes, anterior poliomyelitis, or in two cases of section of the spinal cord. M. Babinski points out that the diverse affections in which it is found have this in common: they bring about some perturbation in the pyramidal system, to which he attributes the phenomenon. But it does not imply a grave affection; it may occur in cases of slight and curable paralysis and disappear with the latter. Conversely, the sign may be absent in cases where the pyramidal system is profoundly altered. It may prove valuable in distinguishing organic from hysterical hemiplegia or paraplegia. Also its presence in tabes would show affection of the pyramidal system which otherwise might remain unknown. In the newborn the phenomenon occurs normally. This confirms the theory of its relation to the pyramidal system, for at birth the latter is not developed.—*Lancet*.

"Typhoid Spine."—Dr. W. S. Newcombe has published an interesting case of "typhoid spine"—an affection the nature of which is disputed—in the *International Medical Magazine of Philadelphia*, September, 1898. Some have doubted the existence of such a condition, claiming that some complication, such as lumbago, is present in the convalescent stage of typhoid fever; others believe that it is due to some inflammation around the spinal column—"perispondylitis";

others that it is due to neuritis; others that it is hysterical. Dr. Osler states that "even if the great majority of these cases are hysterical some may be due to alterative changes of the disease." Inflammations of bone occur much more frequently after typhoid than any other fever. This lends some support to the second theory; but neuritis might also be produced by this spinal inflammation, and many cases of distinct neuritis have been reported. There have been no necropsies to throw light on the subject. Dr. Newcombe's patient was a girl, aged 17 years, who had an ordinary attack of typhoid fever. Towards the end of the fever she complained of pain in the back, and thought it was due to cold which had been applied to reduce the temperature. It entirely disappeared, and she was able to walk about. About two weeks afterwards she was seized with a severe pain in the lower part of the back radiating towards the hips. She could not lie down, and when standing was bent forward and drawn to the right side. The least motion was painful. She improved slowly and in a month was able to move about with little pain. Bicycle riding was ordered to "straighten her spine." Relapses occurred. Salicylates, acetanilid, salol, belladonna, bromide, and trianol were tried without success; finally morphia had to be given to relieve the pain. There was great tenderness over the second and third lumbar vertebræ and she was still bent forward and to the right. Extension weights of about 8 lb. were attached to each foot with a view to decrease the strain on the spine. In about four weeks all tenderness had disappeared. She made a complete recovery.—*Lancet*, October 29.

Relaxation of Muscles in Organic Hemiplegia.—In 1896 M. Babinski read a paper on this subject at a meeting of the Société de Biologie. He observed in several cases of hemiplegia and monoplegia due to a cerebral lesion, a relaxation of muscles, which allowed passive movements in the affected limbs of greater extent than in the sound. His observations particularly refer to the degree of passive movement of flexion of the forearm, which could be carried to a greater extent on the paralysed side. He observed this phenomenon at first in recent cases of hemiplegia with flaccid paralysis without in-

crease, or with decrease, of tendon reflexes. In a case of twenty hours' duration, when the legs were hanging the angle formed by the foot with the leg was greater on the paralysed side; when the forearms were horizontal and pronated, flexion of the hand was also greater on this side. In none of the cases was there amyotrophy. Afterwards he observed this phenomenon in several cases of hemiplegia of several months' duration, with exaggeration of reflexes. M. Babinski thinks that the phenomenon is of the same nature as the drooping of the angle of the mouth which is observed in hemiplegia; it is due to a loss of tonicity of muscles. It is somewhat singular that relaxation of muscles should occur with exaggerated reflexes. In the various cases of hysteria which he observed since his attention was directed to the phenomenon it was absent. He is, therefore, led to believe, without being dogmatic, that it may serve to distinguish organic from hysterical monoplegia and hemiplegia.—*Lancet*.

Affection of the Heart in Cancrum Oris.—In the *Edinburgh Medical Journal* of March, 1898, Dr. Thomas Oliver has published the following case. A domestic servant, aged seventeen years, who had a comfortable home and had always been well fed, began to suffer from face-ache, attributed to a decayed tooth. A day or two later an ulcer formed behind the left upper incisor teeth, which was followed by swelling of the cheek and ulceration of its inner surface. The pain continued and was accompanied by frequent shiverings and prostration. When the patient was first seen, three weeks after the onset, the left cheek was considerably swollen, red, and indurated, and the left half of the upper lip was swollen and protruding. There was a large brawny swelling below the chin and the breath was very offensive. The teeth were loose and the gums were red and ulcerated. There was a large ulcer on the floor of the mouth and another on the inside of the cheek, each covered with a slough. The heart was normal and the temperature was 102 deg. F. Three days later friction sounds were detected over the right base and bronchial râles all over the lungs. On the following day the patient was very ill, the bronchitis was worse, and the pulse was 140 and rather irregular. The area of cardiac dulness had increased, the impulse was more diffused, the apex beat was felt

in the fourth space $\frac{1}{2}$ in. external to the left nipple. The area of dullness rapidly extended, the apex beating $1\frac{1}{2}$ in. external to the nipple and over this area was a loud-blowing systolic murmur. At the end of the fourth week the cheek became perforated. By degrees the health improved and the heart became reduced in size, but the murmur could still be heard several months after recovery. The remarkable points in the case are the occurrence of the disease in a subject who had not passed through a previous illness, or been exposed to any unfavourable influence, the age of the patient, and the heart complication. Dr. Oliver attributes the dilation of the heart to malnutrition of the myocardium either from fever or toxæmia; a similar condition occurs not uncommonly in fevers. He thinks that the murmur was due to the dilation and not to endocarditis. This view appears to us to be scarcely satisfactory. The persistence of the murmur after the dilatation had passed away is opposed to it. Moreover, cancrum oris, like other suppurative foci, would at least give an opportunity for pyogenic or other infection of the endocardium, and so long ago as 1878, Dr. A. E. Sansom described in the Transactions of the Royal Medical and Chirurgical Society an organism found in the blood and diseased tissues — *Lancet*.

Gouty Phlebitis in the Scrotal Region.

—Since the publication of Sir James Paget's classical work gouty phlebitis in the lower extremities has been well known. But the unusual site of the disease in a case communicated recently to the Société Médicale des Hôpitaux by Dr. Le Gendre rendered the diagnosis difficult and even erroneous. A man, aged 30 years, was seized with violent pains at the root of the scrotum, after having stood for many hours every day at the trial of M. Zola. The skin of the affected region was quite normal, but a flabby cord about 3 cm. or 4 cm. in length and mobile could be felt. The temperature was 100.7 deg. F. The patient had previously exhibited gouty manifestations—nephritic colic, epistaxis, and arthritis of the great toe. His father and brother were gouty. The diagnosis of gouty phlebitis was therefore made, and it was supposed that the long periods of standing, by favouring venous stasis, had helped to localise the attack in the venous system of the scrotum. A distinguished surgeon, however, diagnosed in-

flammation of Cowper's gland. The tumefaction became indolent and modified in shape; it formed an ovoid, hard mass about the size of a small almond, with an elongated pedicle, which became lost in the direction of the perineum. At this time another consultant diagnosed fibroma probably growing from the corpus cavernosum. At the end of twenty days the tumour commenced to diminish. An attack of gout in the right foot occurred one evening, and the tumour rapidly disappeared, leaving a thickened varicose vein running towards the obturator foramen. Resolution was soon complete. Such rapid absorption does not occur in thrombosis with a well-formed clot; the exudation was therefore probably the result of periphlebitis. — *Lancet*.

Typhoid Cholecystitis and Cholelithiasis.

—The *Johns Hopkins Hospital Bulletin* for May, 1898, contains an important paper on this subject by which Dr. Cushing gives some facts of great interest. It appears that the gall-bladder, like Peyer's patches, is a site of election for the typhoid bacilli. In 1891 Blachstein noticed their constant occurrence in the gall-bladder of rabbits after experimental inoculation. Later, Professor Welch discovered that they persisted in this situation; in one animal they were found 128 days after inoculation, when they had disappeared from every other organ. Acute cholecystitis may appear in the late stage of typhoid fever, but there is a group of cases in which it appears some months after the attack and always in association with cholelithiasis. The connection between typhoid fever and cholelithiasis was first pointed out in 1880 by Bernheim, and has been confirmed by several writers. In Professor Halsted's clinique in the Johns Hopkins Hospital, ten out of thirty-one cases of cholecystitis with cholelithiasis which were operated on gave a history of typhoid fever, the interval varying from a few months to twenty years. Such a long interval by no means negatives the connection, for the bacillus has been found in a case of cholecystitis as late as fourteen years after an attack of typhoid fever. Similarly abscesses of bone may follow typhoid fever after long intervals; in a case recorded by Buschke the interval was forty-six years, and yet the bacillus was cultivated from the pus. These cases well illustrate that the germs of disease may

remain latent in the body for an indefinite period—a doctrine which is only beginning to be appreciated, and which has far-reaching possibilities. Dr. Cushing reports a remarkable case of cholecystitis and cholelithiasis in which cholecystotomy was performed and the typhoid bacillus found in the gall-bladder, although there was no history of previous typhoid fever. The blood-serum gave the typhoid reaction. The widespread occurrence of the typhoid bacillus has only been lately recognised. In 1892 Guarnieri first described an infection of the biliary passages, liver, and spleen, without intestinal lesions.—*Lancet*.

Syphilitic Phlebitis.—Dr. Barbe (*La France Médicale* of August 12) very truly remarks that syphilitic phlebitis is not often described, perhaps because it is imperfectly known and passes unnoticed. Sometimes the lesion is localised (venous gumma), sometimes it affects a certain extent of the vein. Langenbeck was one of the first who drew attention to syphilis of the veins. In 1881 he extirpated a tumour in the neck as a cancer. The microscope, and ulcerations in the mouth and throat which followed, showed it to be a gumma. It grew from the external coat of the jugular vein. He relates another case in which a similar diagnosis was made and a gumma of the femoral vein was removed. The patient died from pyæmia. In 1872 Gosselin observed in a syphilitic woman, aged 65 years, a painful and tender swelling in the upper part of the calf, beneath and not adherent to the skin. Palpation revealed a cord 4 centimetres long and 1 broad. There were no varices. He diagnosed gumma in the external coat of the external saphenous vein and under specific treatment the patient was relieved in fifteen days. Gosselin further observed gummata in a case of secondary syphilis, in the cellular tissue and in both internal saphenous veins. Dr. Heuzard, in his *Thèse de Paris*, 1898, describes secondary and tertiary phlebitis; in the former several veins are affected together or one after the other, in the latter the phlebitis may be circumscribed (gumma) or diffuse. Secondary phlebitis affects principally the saphenous veins. It manifests itself at first by congestion which may take the form of red lines corresponding to the course of the veins. Palpation reveals tender cord-like induration of the veins and œdema of the leg. Specific treatment is

rapidly successful; sometimes there is a relapse. The veins usually remain permeable. In tertiary phlebitis the veins are sometimes obliterated, sometimes varicose and elongated. Recovery is not always complete; sometimes induration remains.—*Lancet*.

The Etiology of Rheumatism.—Reinhard (*Münchener Med. Wochenschrift*, Sept. 13, 1898). The knowledge of the etiology of rheumatism has been advanced by the recognition that it is connected with pyæmia, and that acute rheumatism may follow slight local inflammations, such as sore throat.

Bloch has lately published cases of ante-polgarthrites which followed whitlows, boils, fistula in ano, and otitis; and Reinhard has seen two cases of rheumatism which followed gumboils. Considering that the mouth and throat are the most usual sites for the entry of the micro-organisms, he thinks the chief prophylaxis against rheumatism to consist in attention to these parts, such as cleaning the teeth, removing hypertrophied tonsils, &c. In the Transvaal those who suffer most from rheumatism are those who have no idea of cleanliness either of the skin or mouth, viz., the Boers. Again, just as an acute angina may be cured by an anti-rheumatic drug such as salicylate of sodium, so in one of the author's cases chronic rheumatism of four years standing was cured by the successful treatment of a co-existing chronic pharyngitis. However suggestive these observations may be, we agree with Dr. Rabl that the infective origin of rheumatism is not yet proved, either clinically or pathologically.

The Poisonous Properties of Pure Water.—Hans Koepe (*Deutsche Med. Wochenschrift*, September 29, 1898) discusses the effect of drinking chemically pure water, *i.e.*, water containing no dissolved salts or gases. Purity of water in this sense is determined by testing its electrical conductivity; the greater the conductivity the more impure is the water. It is exceedingly difficult to prepare water with a conductivity less than 2.13 on this scale. For comparison it may be said commercial distilled water has a conductivity of over 49, and ordinary spring water of 500 to 600 or more. Now the action of distilled water is well known: it withdraws salts from the

tissues, which swell up by imbibition, and is a dangerous protoplasmic poison. When swallowed it causes a swelling up of the superficial layers of the gastric epithelium, which die and are exfoliated. That washing out of the stomach with distilled water has a bad effect is proved; really pure water would be worse still. A remarkable fact is that waters occur in nature purer than ordinary distilled water. Hence the practical importance of the subject to medicine. Among these is water obtained from clear natural ice, which may therefore cause gastric catarrh and vomiting when given to patients to suck. Artificially made ice never produces such pure water on melting, and is therefore safer. Hence guide-books always warn travellers not to drink water from snow, glaciers, or clear mountain torrents, which instead of quenching thirst produce gastritis. The most remarkable instance is that of a spring at Gastein, which has been known for centuries as the "Poison Spring," and no one will drink its water. Yet no poison has ever been found in it. The simple fact is that the water is purer than distilled water, and in consequence has the same injurious effect.

Infectious Hæmatemesis.—The *Lancet* of November 6, 1897, called attention to the bacteriological examination of the blood during life—a comparatively new method of investigation which seems destined to be of great service in the future. Its advantages over bacteriological examinations in the cadaver—on which, for internal diseases, we have had in the past to rely almost entirely—must be manifest. In the *Lancet* of January 15, 1898, we announced that MM. Triboulet and Coyon had found constantly in the blood of patients suffering from acute rheumatism, a diplococcus, which seems to be much more probably the long-sought cause of the disease than the various organisms found after death. The pathogenesis of gastric ulcer is still an obscure subject; microbes are supposed, but only hypothetically, to be the cause, in some cases. In the following case, published in the *Journal des Praticiens* of February 3rd, 1898, by M. Giraudeau, bacteriological examination of the blood gave evidence in support of this view, and also threw much light on the case. A woman, aged 43 years, who had never suffered from any

gastric symptoms, was suddenly seized with hæmatemesis, amounting to from half to three-quarters of a litre, which was followed a few hours later by copious melæna. The same events occurred two days afterwards. On the next day she was admitted to hospital so enfeebled that artificial serum had to be injected subcutaneously. A third attack of hæmatemesis and melæna took place on the seventh day. Before the first hæmorrhage occurred the patient had rigors, and when admitted her temperature was 104 deg. F.; on the next day it was 104.7 deg. in the morning, and 105 deg. in the evening; on the following days it showed great oscillations, reaching or passing 104 deg. in the evening, and falling to 102 deg., and later to 100.4 deg. in the morning. There was no tenderness over the stomach; the abdomen was tympanitic. The symptoms of the patient did not correspond, therefore, to any well-known type of disease. Evidently there was an infectious process. But what? The serum test showed that it was not a case of ambulatory typhoid fever with gastric ulceration. A mitral regurgitant murmur was then heard; there was evidently infectious endocarditis. The staphylococcus aureus was found in the blood, and a few days afterwards the staphylococcus citreus. Under quinine the patient improved, the temperature oscillating between 100.4 deg. and 102.2 deg., but on the twenty-fifth day it rose to 103.2 deg., and there was phlebitis of the left crural vein. The patient recovered, but the cardiac murmur persisted. The case was, therefore, one of staphylococcic septicæmia with gastric, cardiac, and venous lesions. The patient had been much worried, and had endured privations before the attack, which, no doubt, predisposed her to infection. Infectious hæmatemesis may also occur in small quantities and in repeated attacks. A man, aged 45 years, with suppurating inguinal bubo, suffered from pyrexia, profuse sweats, and vomited his food every day with little blackish clots; the symptoms ceased only when the bubo was opened. The existence of these blackish vomitings in surgical septicæmia is not rare. Infectious hæmatemesis may occur in typhoid fever, tuberculosis, syphilis, &c. In fatal cases nothing like the ordinary round ulcer of the stomach is found; the source of the hæmorrhage is a slight erosion often difficult to find; it appears to result from a miliary abscess.—*Lancet*.

THERAPEUTICS.

The Treatment of Obstinate Dropsy.—

James Tyson. A patient with general anasarca has his tissues distended with serum. There is effusion into one or both pleural sacs, and probably into the peritoneal cavity. The object is to get rid of this dangerous accumulation.

This may be accomplished, first, by cutting down the liquid ingested, and, secondly, by increasing the output of liquids. The first of these has received less consideration than it deserves. Dr. Tyson finds the most satisfactory way is to restrict the patient to a milk diet. He begins with 2 to 4 oz. every two hours, keeping this up till the patient begins to complain of hunger. Often the dropsy does not begin to disappear till hunger is complained of. After a decided effect is produced on the anasarca, or it has entirely disappeared, the quantity of milk is grudgingly increased. Then, gradually, other articles of food are added until the patient's appetite is satisfied.

Further, this restricted diet favours the second part of the treatment. Dr. Tyson has frequently found that a patient would not respond to diuretics whilst eating freely.

Rest in bed is indispensable. In cardiac and renal cases rest alone will sometimes entirely remove a dropsy.

Rest and regulated diet secured, measures to increase the output of fluids by the kidneys, bowels, and skin, may be adopted. It is waste of time to give diuretics without the preliminary action of a purgative. The saline purgatives are most suitable. Dr. Tyson uses Rochelle salt—half-an-ounce to an ounce half-an-hour before food, preferably before breakfast. Epsom salts are probably more efficient but less palatable. The compound jalap powder is also an admirable aperient in one or two drachm doses. Calomel, in doses of $7\frac{1}{2}$ to 10 grs., with an equal quantity of sodium carbonate, may be substituted. The mercurials act more slowly than the salines; but they are useful adjuvants in hepatic disease with ascites. It is of great importance to give the saline in as small a quantity of water as possible, preferably not more than four ounces. Having secured a free action of the bowels, with the patient at rest on a restricted diet, a diuretic may be given. "No question

of general therapeutics is more unanimously answered than that digitalis is the best diuretic available." Dr. Tyson begins with ten minims of the tincture four times a day, or fifteen minims three times a day. If no diuretic effect is produced by the end of forty-eight hours the dose may be increased to a drachm in the twenty-four hours. The effect is also recognised by a slowing of the pulse, and should this fall to sixty, or should an irregularity appear in a formerly regular pulse, the drug must be discontinued.

Digitalis is a drug which must be intermitted both to secure its efficient action and to avert its toxic effects. The drug which should be substituted for it depends upon the cause of the dropsy. In cases of cardiac disease, Dr. Tyson prefers theobromine, which he has found very valuable; at times even superior to digitalis. He gives 45 grs. in the twenty-four hours, in doses of $7\frac{1}{2}$ grs. every three hours. The dosage is kept up for six days, and on the last day digitalis is associated with it and continued after the theobromine is stopped. The diuretic effect is sometimes marvellous—as much as 119 ounces in the twenty-four hours.

In the dropsy of renal disease a diuretic which is not sufficiently appreciated is sparteine sulphate, the active principle of broom. It has been given in too small doses. The dose should never be less than $\frac{1}{4}$ grain to adults, to the amount of 2 grains in the twenty-four hours. It may even be increased to 3 or 4 grains in this period.

Dr. Tyson never feels he has done his duty towards a case of obstinate dropsy when other measures have failed till he has tried the time-honoured combination of calomel, squill, and digitalis. Occasionally he has seen marvellous effects from the combination, particularly in cardiac dropsy, when given in doses of calomel $\frac{1}{2}$ grain, digitalis 1 grain, and squill 1 grain, every three hours until diuresis, free purgation, or both, have been obtained.

The skin is not usually so satisfactory a channel as the kidneys or bowels, because of the profound weakness produced by diaphoresis. He thinks the vapour bath more satisfactory and less uncomfortable than the hot air bath.

One drug only is markedly efficient to produce diaphoresis—pilocarpine. One-fourth of a grain hypodermically should be the maximum dose, and a

powerful effect may be produced if it is associated with artificial warmth. Should dangerous œdema of the lungs arise it may easily be controlled by a hypodermic injection of $\frac{1}{100}$ or $\frac{1}{50}$ of a grain of atropine.

In dropsies due to heart disease the Schott or Nauheim treatment is a valuable auxiliary, so is massage alone.

There are cases in which all these resources fail. Then paracentesis, or puncture, may be required. Sometimes spontaneous rupture of the skin occurs, and large quantities of fluid are thus drained away. Not unfrequently improvement seems to date from such rupture.—*Therapeutic Gazette*.

Dyspepsia.—The following draught is recommended by Burney Yeo as one of the best medicinal remedies for atonic dyspepsia when taken half an hour or an hour before meals:—

R̄ Sodii Bicarbonatis gr. xv.
Tinct. Nucis Vomicae ℥xv.
Tinct. Calumbæ ʒss.
Spr. Ammonia Aromat. ʒss.
Infus. Aurantii Comp. ad ʒj.

M. f. haus. To be taken three times daily, half an hour or an hour before food.—*Practitioner*.

Asthma.—The celebrated "Cigarettes d'Espic" are said to be made of the following ingredients:—

R̄ Belladonna Leaves $5\frac{1}{2}$ parts.
Hyoscyamus Leaves $2\frac{3}{4}$ parts.
Stramonium Leaves $2\frac{3}{4}$ parts.
Phellandrium Aquaticum 1 part.
Extract of Opium $\frac{1}{8}$ part.
Cherry-laurel Water, q.s.

The dried leaves, stripped of their stems, are cut small, well mixed, and then moistened with the opium dissolved in the cherry laurel water. The paper used for making the cigarettes is also soaked in an infusion of these leaves in cherry-laurel water. Usually, in making these cigarettes, a little nitrate of potash is added to the infusion to make them burn freely.—*Practitioner*.

The "Carton fumigatoire" of the French codex—a very useful preparation—is thus made:—Take 7 oz. of grey unsized paper and 2 oz. of powdered nitre; take of belladonna leaves, stramonium leaves, digitalis leaves, and lobelia leaves each 75 grs.; take of powdered myrrh and powdered oliban

each 150 grs. Tear the paper in pieces and soak it in water, then add the powders previously mixed, and pound and beat them all together. Then spread out the soft paste in tin moulds, and dry it in a stove. Finally, cut this quantity into thirty-six pieces, each 6 cm. long and 4 cm. wide. One of these to be burnt in the patient's room.

The following is given as Himrod's cure:—

R̄ Lobelia Powdered
Black Tea Powdered
Stramonium Leaves Powdered } āā ʒj.

Pour upon this mixture 2 oz. of a saturated solution of nitrate of potash, mix thoroughly and dry.—BURNEY YEO: "A Manual of Medical Treatment."—*Practitioner*.

Salophen—Mosler (*Therapeut. Beilage der Deutschen Med. Wochenschrift*, September 1, 1898) has found salophen to be most useful in the treatment of rheumatism. The disadvantages of salicylic acid alone are well known; after the pain and other symptoms have subsided under large doses, it is necessary, in order to prevent a relapse, to continue the treatment. But this is often difficult or impossible, owing to nausea, vomiting, singing in the ears, delirium, or dyspnoea. Mosler's method is to give salicylic acid until the chief symptoms of acute rheumatism have subsided (three to five days), and then to replace it by a daily dose of thirty to forty-five grains of salophen. Salophen prevents relapses better than any other drug, and never upsets the stomach or nervous system; but does not, as Richard Drews (*Therapeut. Monatschrift*, March, 1898) states, act so well as salicylic acid in the acute stage of rheumatism. Excellent results have been reported from the use of salophen in chorea and neuralgia. It is quite tasteless, and can be given for weeks in daily doses of as much as 1 to $1\frac{1}{2}$ drachms. The reason why salophen can be taken without fear of complications is a chemical one. It is not decomposed by acids, and therefore passes the stomach unaltered; but in the alkaline small intestine it splits up into salicylic acid and acetylparamidophenol, but so slowly that salicylic acid can be demonstrated in the urine from the third to the twentieth hour after administration. Its action is, therefore, continuous, and there is never enough

salicylic acid present at a time to produce any unpleasant symptoms.

Rectal Injections of Saline Solution.—

Dr. Eltz (*Therapeutische Monatshefte*, September p. 490) was led to adopt this mode of treatment in many different cases by an accidental observation of a patient with uræmic convulsions, who was treated by rectal injections as ordinary enemata, but who, instead of returning them, absorbed the fluid and was much benefited. Each injection was followed by profuse sweating, and gradual recovery from the uræmic state took place. The treatment is recommended in renal disease, when it is desired to wash out retained products of metabolism. In these cases any large quantity of fluid given by the mouth is liable to cause gastric derangement. No such evil results follow from rectal injections. In atony of the stomach it is also advisable to administer fluid by the rectum rather than by the mouth; and in pertussis, where obstinate vomiting has almost worn out the patient, and reduced him to the last stage of anæmia and exhaustion, this mode of fluid-ingestion may avert a fatal issue. Equally good effects are produced by this treatment in the obstinate vomiting of pregnancy, while its use after profuse loss of blood is well known. Saline solution appears to be more readily absorbed than pure water, and is therefore preferable for such injections as are meant to be retained.

The Diet in Gastric Hyperacidity.—

Sørensen and Metzger (*Münchener Med. Wochenschrift*, September 6, 1898) have made a number of experiments with a view to determine the most appropriate diet for cases of gastric hyperacidity. They find that an exclusively albuminous diet does not cause a great excretion of HCl in an already over acid stomach, as is usually stated. On the contrary, the percentage of free HCl was found to be about the same with an albuminous as with a carbohydrate diet. Therefore, there is no reason for ordering one in preference to the other in these cases. The advantages of an albuminous diet are that it is of smaller volume, has a greater power of fixing acids, and is more quickly got rid of, and hence irritates the stomach less than carbohydrates. On the other hand, human beings cannot well be fed on albumen alone, and pro-

bably the most suitable diet is a mixed one, including fats. More important than the chemical constitution of the food is its form, method of preparation, and fineness of division before reaching the stomach.

The Treatment of Epilepsy by Bromide of Strontium.—

Professor Anthony Roche (*Lancet*, Oct. 15), has not seen a case in which this treatment, carried out according to his directions, has failed, and he has not found the continual use of bromide of strontium followed by any bad consequences, which is an immense advantage over the potassium salt. He has given three drachms daily for weeks without unpleasant symptoms. Prof. Roche commences by ordering half a drachm night and morning in some tonic vegetable infusion; should that not control the attacks he rapidly increases the dose. Thirty grains are given at once when there is any warning of an attack, and repeated every hour if required. By this means an attack has been frequently prevented. To get the full benefit of the medicine it is necessary to give it in large doses and for a long period. Several have complained that they have not had the same good results. Prof. Roche invariably finds that in these cases the dose has been too small.

Oxygenated Water in the Treatment of the Vomiting of Pregnancy and Tuberculosis.—

(*Journal de Pharm. et de Chim.*, No. 7, p. 364, 1898).—The authors have prescribed for three years oxygenated water for cases of these classes, and they have been very rarely unsuccessful in their treatment. They use the oxygenated water, diluted in the proportion of a tablespoonful to a litre of water mixed with some wine or milk. Silver spoons should not, of course, be used for measuring or mixing the water. It is sometimes necessary to continue the treatment for two or three weeks to prevent the return of the attacks.—*Med. Chronicle*.

Blood-letting in Uræmia.—

Sturwitz (*Boston Med. and Surg. Jour.*) records a case of scarlatinal nephritis in a seven year-old boy, attended by ascites and œdema, which could not in the least be relieved by the usual treatment. He resorted to venesection—which he considers an effective diuretic agency under certain circumstances—and

an abstraction of a small cupful of blood brought on rapid diminution of the œdema within twenty-four hours.

Professor Larache resorts to blood-letting in uræmia. One patient suffered with anuria of pyelonephritic origin for six days. Venesection brought on abundant secretion of urine, which placed the patient at once beyond any danger. The amount of blood extracted amounted to 25 oz., in other cases to little more than half of that quantity. In another case—that of a woman of 29 who was brought to hospital suffering from severe uræmic convulsions due to chronic nephritis—venesection brought on almost at once a cessation of the convulsions and abundant secretion, about 8 litres in 24 hours, of urine. In the third case—that of a girl suffering with uræmic convulsions due to acute nephritis—the convulsions disappeared a few hours after the venesection, but diuresis was not influenced to any marked extent. Larache considers a favourable general condition and increased blood-pressure an indication for blood-letting.

The Treatment of Serous Exudations in the Pleural Cavity by Salicylate of Sodium.

—In a recent issue of the *Archives Russes de Pathologie* Poliakoff insists upon the utility of salicylate of sodium in the treatment of pleural effusions. He has never seen disagreeable symptoms produced, and recommends that the drug be given in cachet, and immediately after ingestion of the cachet that the patient take a drink of some alkaline water. Should the dose of the salicylate seem to depress the heart, this may be avoided by the simultaneous use of a little caffein. After the salicylate has been administered for three or four days its use is suspended for a day or two, and it is then renewed.

It would seem from Poliakoff's studies that the salicylate is particularly useful in chronic apyretic pleurisy. He records six cases in which this treatment was used. In five the salicylate produced satisfactory results.—*The Therapeutic Gazette*.

SURGERY.

Suture of the Clavicle for Simple Fracture.—Foote, S. M. (*Medical News*, May 28, 1889).—A healthy, well-built lad, aged 13, sus-

tained a fracture of the right clavicle, rather outside the middle of the bone, two months before his admission to hospital. The fracture united with the fragments overlapping more than one inch. The union was broken down, the ends of the bone were drilled, and a stout kangaroo-tendon suture was passed through them and tied. The arm was confined to the side for ten days, and was carried in a sling for another ten days. The patient made a good recovery, with a minimum amount of deformity.

In Germany, France, and Italy several operations of this character have been recorded. The writer, after a study of reported cases, enumerated the following conditions, which may render suture of the clavicle advisable: (1) Irreducible deformity or constantly recurring displacement of the fragments, (2) Interposition of muscle between the broken ends. (3) Pressure upon or injury to a nerve. (4) Injury to a vessel, causing a large hæmatoma. (5) The projection of a sharp piece of bone under the skin. (6) Compound fracture. (7) As a secondary operation in cases of continued pressure upon nerve-trunks and in cases of non-union. In most of the operations previously reported the fragments were joined with silver wire; in a few silk was used.—*Medical Chronicle*.

Secondary Hæmorrhage following the Removal of Post-Nasal Adenoid Vegetations.

—Dr. W. Preble (*Bost. Med. and Surg. Jour.*, May 19, 1898) writes on this very unusual complication. He removed vegetations from a girl aged eleven years. The bleeding was not severe. The operation was quite successful and nasal breathing was restored. But on the seventh day a sudden hæmorrhage occurred and the girl was carried into the house fainting. Under cold syringing the bleeding stopped. It recurred and was stopped by plugging the posterior nares. On the eighth day a sudden gush of blood came on and she died before assistance could be rendered. There was no history of hæmophilia. Dr. Preble has collected twenty-one cases of serious primary hæmorrhage after this operation (of which four proved fatal), and five cases of secondary hæmorrhage. Of the latter, three of the patients were French and two were Danish. There does not appear to be any case of secondary hæmorrhage recorded in English literature.—*Lancet*.

Case of Tearing Away of the Urinary Bladder from its Pelvic Connections.—

F. Bird (*Australasian Med. Gaz.*, May 20th, 1898), A lad, aged 19, was thrown from his horse. Some hours afterwards he was found suffering from concussion of the brain. He was taken home, and recovered consciousness, but attention was not drawn to any urethral or bladder injury until the bladder became distended, when complete retention was found. On examination, there was no bruising in the perineum, no tenderness, no fulness, no indication whatever that the perineum had been subjected to violence. There was no bleeding from the urethra, but a catheter at once drew blood, and no attempt, even under chloroform, succeeded in withdrawing urine.

The bladder was aspirated above the pubes, and a large quantity of urine drawn off. The following day the patient was operated upon. The urethra in the region of the bulb was first opened, but the exploring finger failed to reach the bladder, which was greatly distended, and situated far up in the abdomen. A torn triangular ligament was revealed, and a traumatic cavity behind and below the pubes. The bladder was opened through the abdominal wall. A large quantity of urine escaped. All the structures which anchor the bladder to the pelvis had been torn away. Several fingers could be freely passed from above behind the pubes into the perineal wound. The pubo-prostatic ligaments had disappeared, and two small thin shells of bone were discovered pulled off the pubes. With the finger in the bladder, the remains of the membranous urethra were found as a small tuft on the anterior portion of the prostate, which was poorly developed. The lumen of the tube was tightly closed by spasm of the muscular fibres, producing complete retention. It was impossible to pass a catheter into the bladder through the prostate, so it had to be passed from within the bladder. A rubber catheter was passed through the abdominal wound, through the bladder, through the torn membranous urethra, and out through the perineal wound. The cave of Retzius and the space produced by the injury behind and below the pubes were carefully packed with gauze round a drain tube. This gauze was not removed for three days, during which time urine passed both ways, most of it suprapubically.

After the removal of the gauze, the subperitoneal tissue was packed very lightly, and after a week, when the parts were in an agglutinative state, the packing was discontinued. A catheter was now passed through the penis into the bladder, with difficulty, under chloroform.

The case progressed favourably. Later the catheter was left out on account of cystitis, there was retention of urine and great pain in endeavouring to pass it. The upper wound was several times reopened during spasmodic attacks. A silver catheter was passed every day for several months, until a No. 10 passed into the bladder with ease.

It is usually stated that in those cases in which the urethra is torn asunder all the classical symptoms are pronounced, viz.—free urethral hæmorrhage, total retention of urine, and a large perineal swelling. In this case two of these were absent, while retention of urine was, from the condition of the parts, a necessity. In complete rupture retention is very generally seen, but not in all cases, for Pearce Gould in March, 1893, refers to the case of a lad who, though his urethra was completely divided, passed water without difficulty three days afterwards.

If retention had not existed in the above case, there would have been liability to fall into the mistake so graphically recorded by Herbert Page in the *British Medical Journal* for 1896. In this case the enlarged cave of Retzius contained blood and urine, which was drawn off by catheter, and was naturally supposed to come from the bladder. This extra-vesical collection of urine was also aspirated from the front. The entire absence of bruising was remarkable. However, Jacobson mentions that complete rupture of the urethra may co-exist with a mere contusion of the perineum. The writer believes the sudden momentary impact of the pommel of the saddle was the cause of the injury. The urethra is generally torn in front of the triangular ligament, this firmly-fixed structure being a prime factor in the production of the laceration; but in this case the triangular ligament itself was much torn, which must have required great violence by a body small enough to act only in the pubic arch. When the triangular ligament is torn, it is nearly always accompanied by fracture of the

pelvic bones, or disjuncture, momentary or permanent, of the symphysis.

The very satisfactory result in this case is due, in the writer's opinion, to the fact that repeated attempts at catheterism were not made, that the bladder was early tapped above the pubes, thus preventing pelvic cellulitis, and to the packing with gauze of the spaces behind the pubes.—*Treatment.*

Sequestrum as a Foreign Body in the Urethra.—Dr. S. Grosalik (*Centralblatt f. d. Krank. d. Harn-und Sexual-Org.*, p. 642, 1897) details a case of foreign body in the urethra, a sequestrum probably pelvic. A young man, aged 26, had suffered for nine months from an obstinate purulent urethral discharge. One night, after coitus, he had severe pain in the deep urethra and then during urination, a disagreeable feeling remained in the urethra. The pain was continuous, independent of urination, but increased by it. Afterwards there were traces of blood and whitish discharge; for several days there was œdema of the penis and scrotum. After nine months' treatment for gonorrhœa he consulted the writer, calling his attention to a hardness under the skin at the scrotal border. He had never had gonorrhœa, was married, and had had no illicit intercourse. Pressure on the hard body at the peno-scrotal angle caused pain. There was abundant discharge, containing pus and bacteria but no gonococci. An elastic catheter was stopped at the penoscrotal angle. The stream of urine was of good volume. An endoscopic tube, No. 21, did not reach the obstruction, but the urethra in front was normal. A Thompson's searcher struck the hard body with a click, and a diagnosis of urethral stone was made. An attempt at removal with urethral forceps failed, though the body could be grasped. As there was no grit left on the teeth of the instrument it was concluded that the stone was of considerable hardness. Removal by external urethrotomy under chloroform was decided upon. After anæsthetisation an attempt was made to dislodge the foreign body from its bed with a sharp spoon. By this manipulation the body was removed with a little bleeding, a catheter *à demeure* was left in for forty-eight hours. Recovery followed. The body was found to be a bit of bone, half an inch long, quarter of an inch wide, smooth

on one side, rough on the other, with a sharp and jagged border. The bone was a sequestrum, apparently from the pelvic brim. The bladder wall had probably formed an adhesion with the affected bone, and the sequestrum had ulcerated through. It had not remained long in the bladder, as there were no incrustations. There was a history of a fall twelve years before, long-continued illness in bed, with trouble in one hip-joint; a year or more passed before the patient regained full use of the limb. This was followed a few years later by chronic osteomyelitis in the bones of the arms, the sequestra separating without pain. The same had probably occurred in the pelvis.

In 1881 Ungerer collected all the cases of fragments of bone occurring in the urethra and bladder; of these in only five was the foreign body a pelvic sequestrum. Since then Heydenreich and Gayet have each observed one, and this report by the author makes an eighth. In all the cases the bone trouble occurred in childhood with complete healing, and many years had elapsed, in one case thirty years, before disturbance of the urinary organs occurred. In four cases the foreign body lodged in the urethra, three times at a distance of 6.9 cm. from the meatus, and once in the membranous portion. Three times the sequestrum remained in the bladder as a nucleus of a stone, and in the other four cases it first entered the bladder. As to the entrance of bone fragments into the bladder, Ungerer collected forty-one cases from gunshot wounds, fifteen cases from fractures of pelvis, thirteen from ectopic gestation, eight from dermoid cysts, and six from unknown causes.—*Jour. of Cutaneous and Genito-Urin. Dis.*

Fat Embolism after Forcible Straightening of Contractures.—Rare as fat embolism is as a sequel of comminuted fracture, it is rarer still after the forcible straightening of deformities; only four authentic instances have been recorded. Dr. Erwin Payr (*München. Med. Wchnschr.*, July 12, 1898) records a fifth.

A girl, aged 16, presented a flexion-contracture of the right knee, from an antecedent osteomyelitis of the tibia. The joint was freely bent and then straightened under ether. The operation was followed by much pain and general restlessness,

and the next morning by the most profound collapse. The temperature was normal. There was considerable dyspnoea. The patient, although conscious, was very restless, and coughed up a quantity of bloody mucous. In spite of very free stimulation, she died in the afternoon. On examining the body, there was some fluid blood in the right ventricle, with fine droplets of fat floating in it. The veins of the right lower extremity, from the popliteal as high as the vena cava, were filled with blood, partly clotted and partly fluid, the latter mixed with fat droplets, easily recognisable with the naked eye. Similar blood was found in the right knee-joint. There was no fracture of either of the component bones. The cortex of the bones was thin, and the spongiosa so soft that it was easily indented with the finger. The lungs, examined microscopically, showed an extreme degree of fat embolism.—*Edinburgh Med. Jour.*

Perineal Abscess: Pyæmia treated with Antistreptococcic Serum: Recovery.—Mr. Lamford Knaggs (*Lancet*, September 17, page 753). A man aged, forty-three, had a large ischio-rectal abscess, which formed a prominence at the root of the penis, burrowed into both ischio-rectal fossæ and communicated with the urethra. The progress after operation was uneventful, but at the end of seven weeks, when the wound was small, he had a rigor and a temperature of 103.6° F. On the following days there were other rigors and much pus escaped from a closed drainage tube wound. Antistreptococci serum (10 c.c.) was injected daily for a fortnight. There was bronchitis and hæmoptysis. An abscess formed over the outer condyle of the right humerus. The excursions on the temperature chart, which reached 105.4°, steadily, but slowly, diminished from the commencement of the serum treatment and did not exceed normal after the end of the fortnight. The curative effect of the serum on the chest symptoms was very marked.

Laryngoscopy in Children.—Examination of the larynx in children presents peculiar difficulties, and the ordinary method fails, as a rule, to give any satisfactory result. A method which combines depression of the tongue along with traction upon it has been found useful, arching of the dorsum of the tongue is prevented, and at the

same time the epiglottis is drawn forwards, so that the superior aperture of the larynx is rendered more patent. More than one method of applying this principle has been adopted. Petersen, of Berlin, (*Jour. Laryng.*, London, June, 1898), briefly reviews this subject. He found that, in his own hands, a light tongue depressor, Mount Bleyer's, proved very useful, the curved extremity of the spatula permitting a grip upon the base of the tongue. His examination is conducted as follows:—The child is placed on the lap of an assistant, the arms, legs, and head are fixed, the latter being inclined slightly backwards; the mouth is opened by means of the spatula, which is gently passed backwards along the tongue to its base, and is pressed into the hollow in front of the epiglottis; so that the tongue is drawn forwards and slightly upwards by the pressure of the instrument. The laryngeal mirror is quickly introduced into the back of the throat; at the next inspiration, in most cases, a satisfactory view of the larynx is obtained, even when the patients struggle violently. If, at the first attempt, the spatula or the mirror is not in the right position, or the view is obscured by mucus, the instruments are withdrawn, and the operation is repeated a second or third time if required. The amount of traction upon the tongue necessary to draw forward the epiglottis varies in different cases, but the writer has never seen injury or hæmorrhage result. It may be mentioned that Rauchfuss found Fränkel's tongue depressor of service for drawing forward the tongue and epiglottis in such an examination.

Sutherland and Lambert Lack (*Lancet*, London, September 11, 1897), in a paper upon Congenital Laryngeal Obstruction, describe their success in obtaining a view of the larynx in six cases suffering from this condition. The same principle was followed, but in a somewhat different manner. The infant was held in the usual position for laryngoscopy; the index finger of the left hand was passed into the mouth over the base of the tongue, and the terminal phalanx was hooked round the hyoid bone, which is in this way well pressed forwards; the rest of the finger held down the tongue out of the way, and, with the left thumb pressed up under the chin, the child's head was steadied. A small laryngeal mirror was next introduced in the usual way, and the larynx was

brought into view. The question of an anæsthetic may require consideration in some cases, but the advisability of giving chloroform does not find favour with some. A claim has been put forward in favour of Kirstein's autoscopia, or direct examination of the larynx without the aid of a mirror, for infants and children. Kirstein asserts that in very young children it may be used in preference to laryngoscopy; they may be examined with or without an anæsthetic. In either case the head is drawn over the edge of the table, and is held by an assistant. The autoscope is then taken in the left hand, the spatula being directed downwards so that the base of the tongue is pressed forwards; the child's head is gradually raised or lowered until the angle is reached at which the interior of the larynx comes into view.—*Edinburgh Med. Jour.*

Restoration of Severed Parts.—The possibility of restoring severed parts, even under unfavourable circumstances, is not so generally appreciated as it should be, and attempts which might be successful are not made. Three cases have lately been published in which the severed external ear was successfully replaced.* In one (Dr. Brown's) the circumstances were anything but encouraging. The ear had been bitten off by a horse and was found lying in a stable yard. Neither surgical instruments or antiseptics were available; a common needle and thread had to be used. In the other two cases (Dr. Purcell's) the surgeon adopted the ingenious plan of keeping the ear warm and endeavouring to restore the circulation by hot salt bags. Several cases of union of severed finger tips are recorded. In the *Johns Hopkins' Bulletin*, Oct.-Nov. 1892, Dr. Finney has published a case of successful suture of severed finger-tips after seven hours. The middle finger was cut off just below the last joint through the phalanx, the the ring finger at the root of the nail. The raw surfaces were freshened and the tips were attached each by four sutures. Dr. Finney used antiseptic dressings but not solutions, because bichloride of mercury and carbolic acid produce a thin layer of coagulation necrosis. The wounds united by first intention. In a recent number of the *New York Medical Journal* appears an account of the following

case, published in the *Louisville Medical Monthly* by Dr. John C. Laurens. A coloured man in using a heavy axe cut through his shoe and severed the metatarsal bone of the first toe through the head, completely disarticulating the toe, and also cut off the second toe in front of the metatarsal joint. He was seen four hours afterwards. The shoe and sock were cut away and the second toe was found separated, whilst the first was hanging by a mere string of skin, every muscle and vessel being cut. They were united by interrupted sutures which included the tendons. A dressing of iodoform and boric acid, equal parts, was used and a splint was applied. The iodoform had to be discontinued because it proved irritating. Union by first intention occurred over more than half the wound, and there was but little pus where granulation took place. On the third day sensibility was present in both toes, and in a week the patient could move them a little. Finally they were strong, movable, and sensible; and except for a little tenderness the foot was as good as ever.

Natural Immunity to Snake-Bite. Lewin (*Deutsche Med. Wochenschrift*, October 6, 1898), finds by his experiments that the hedgehog which is naturally immune against the poison of vipers, has no substance in its blood which could cause the same immunity in other animals when injected into them. This is true of the normal blood of the hedgehog as well as after treatment with the snake poison. Again animals which eat snakes, and probably vipers among them, do not in this way become immune to the viper poison when introduced in any other way, endermically, subcutaneously, or intramuscularly.

Foreign Bodies Accidentally Left in the Abdominal Cavity during Operation.—Dr. Herman J. Boldt (*Am. Gynæ. and Obst. Journ.*, N. Y., April, 1898) has collected fifty-four cases in which foreign bodies, such as sponges, gauze pads, and clamps have been left in the abdominal cavity during operation; of these only fifteen have been published. In only two was the mistake discovered immediately after operation, and the the patient returned to the operating table and the foreign body removed. In many of the cases symptoms developed many months after the operation; in one, the patient a year afterwards developed

* *Lancet*, June 4 and 11, 1898.

symptoms of intestinal obstruction, and was prepared for operation, when a gauze pad was passed in an evacuation. A considerable number ended fatally. In the majority the foreign body finds its way into the intestine; if into the large intestine, it is usually voided with comparative ease. If it does not perforate the intestine, the foreign body usually finds its way to the surface and produces local symptoms, which lead the surgeon to interfere, or it may result in abscess or fistula. Dr. Boldt deplors the frequency of this accident, and the reluctance on the part of operators to publish their cases, as he thinks that by so doing others would be led to take greater precautions.

The precautions he takes are as follows:—Small pads are discarded almost entirely, and if required are never left in the cavity, but immediately removed when they have served their purpose; if a small area in the pelvis is to be tamponed, a long strip of gauze is used, and to its free end a clamp is attached, or else the end is left outside the wound in the abdomen. For protecting the peritoneal cavity *in toto*, sterilised towels are used; for smaller surfaces, large gauze compresses, to which a long piece of silk or tape is attached, and to the free end of this a pair of forceps is applied. No pad used during the operation is permitted to be cut or torn to meet an emergency. No discarded pads are to be thrown on the floor, but placed in a special receptacle. All pads and forceps are controlled by double count, before the beginning and at the conclusion of an operation. Dr. Boldt either personally supervises the controlling count or has a reliable assistant to do so.—*Edinburgh Med. Jour.*

The Abdomen Opened Three Times in a Fortnight.—Great Northern Hospital. Mr. H. Allingham (*Medical Press*, Oct. 19, p. 409) operated on a woman, age 30, who had been admitted with the following abdominal symptoms:—Distended abdomen, pain, rapid pulse and occasional vomiting. As the symptoms increased, the abdomen was opened. On introducing the hand into the pelvis it was found that she was suffering from double pyosalpingitis, the omentum and intestine being adherent to the left ovary. The omentum and intestine were separated from the ovary and tube, and both the ovaries and tubes were removed. Both tubes were full of pus and ruptured on being

removed. The pelvis was carefully sponged out. For the next four days the patient did well, but at the end of that period vomiting began again and she became distended, and was in great pain. In Mr. Allingham's absence, Mr. Mower White opened the abdomen and found the stump of the omentum adherent to a coil of small intestine, kinking it, and so causing obstruction. He freed the adherent omentum and relieved the obstruction. The patient did well for a week. Then, again symptoms of obstruction returned—vomiting, great pain, distension, whilst coils of intestine could be seen through the abdomen in a great state of peristalsis. Mr. Allingham, therefore, again opened the abdomen, and again found the stump of omentum adherent to a piece of intestine and obstructing it. The adhesion was freed, and this time Mr. Allingham fixed the stump of omentum into the upper angle of the abdominal wound so as to prevent the possibility of it again adhering to intestine. He remarked on the rarity of such a case, and pointed out the necessity of acting promptly. He also thought that the inflamed condition of the omentum was the cause of its so readily adhering to the intestines. The patient made a complete recovery.

Missed Labour.—Dr. Mary Scharlieb (*Brit. Med. Jour.*, Sept. 17, p. 785) publishes an undoubted case of missed labour, which she claims as unique. Previously recorded cases appear to have been cases of ectopic gestation.

A woman, aged twenty-nine, was admitted to hospital on September 26, 1894. She had been married eight years, and had an easy first labour. Her last period was in October, 1893. She believed herself to be pregnant, but she had attacks of cramp like pain and passed a mass of pink jelly and clots. She continued very ill up to the time of her expected confinement in July. No labour occurred. Early in September she had vaginal hæmorrhage and thick yellow discharge.

On admission, she looked ill and worn. The temperature was 102° F., the pulse 120, and the respirations 26. The legs were swollen, the abdomen was tense and œdematous, and enlarged beyond the usual size at term. The outline of the child could be felt through the swollen tissues per vaginam. The lower segment of the uterus partly

blocked the pelvic cavity, but no sign of cervix or os could be detected. Above and behind the pubes a narrow slit was found, through which a bougie could be passed. It entered its full length and appeared to lie immediately beneath the skin. Ectopic gestation was diagnosed.

Laparotomy was performed. The gestation was found to be uterine. The uterus was adherent to intestines and to parietes. When the membranes were incised, exit was given to a foetal puriform fluid. The child was large and well developed. The epidermis was peeling and the bones of the head were loose. The uterus was thin and friable, and lined with a greenish white membrane. It was so disorganised that it fell into many holes in separating it from its intestinal adhesions, which were extensive. The uterus was amputated. There was no indication of os or cervix. The patient died about a month after the operation.

A method of Taking an Impression in Cases of Fractured Jaws.—Dr. Dorrance, of Michigan, has devised a scheme for taking such impressions. He always plaster, regardless of the position of the parts. After the model has set he saws it in two at the point or points of fracture. He then adjusts the pieces in the position which he thinks is correct and vulcanises his rubber splint. By this method it is unnecessary to adjust the parts before an impression is taken.—*Brit. Jour. of Dent. Science*, Sept.

Caries of the Hyoid Bone: Extirpation: Recovery.—Ullmann (*Wien Med. Presse*, 1898 No. 23) records a case of caries of the hyoid bone, which he says has not previously been described. The patient was a man, aged twenty-eight, with a tuberculous family history. Two years previously, after a winter cough, an abscess developed in the neck, above the thyroid cartilage, from which he recovered. Three months later another abscess broke spontaneously, and got well. A year after the first trouble an abscess again developed, which left an intractable fistula. After a year a radical operation was performed. The fistula extended down to the hyoid bone, which was bare of periosteum. The muscles were separated from the body, which was excised; this revealed a fistula lined with tuberculous granulation tissue extending along the left greater cornu. It was therefore decided to

extirpate the remainder of the bone, and this was carefully done, the tongue being fixed by a thread to prevent it from being swallowed. The wound healed in three weeks. A noteworthy point was that speech was good, and the mobility of the tongue normal. Nothing was detected laryngoscopically either before or after the operation.—*Brit. Med. Jour.*

Pulsating Vessels on the Posterior Wall of the Pharynx.—This condition is rare. It is found chiefly in the aged, especially in females, and gives rise to no subjective sensations in the throat. Of the four cases described by Dr. Brown Kelly (*Glasgow Med. Jour.*, January, 1898), three were observed in patients over seventy years of age. The pulsation is generally seen behind the posterior faucial pillars, projecting from the angle between the posterior and lateral walls of the pharynx.

Most writers regard the vessel as an enlarged ascending pharyngeal artery, but some suggest that it may be an abnormal vertebral. Brown Kelly excludes the latter suggestion, so far as his four cases are concerned, for he found that the pulsation in the pharynx could be checked by moderate pressure on the large vessels of the neck above the thyroid cartilage. In regard to the ascending pharyngeal, he thinks it highly improbable that so small a vessel could become dilated to such a degree without any discoverable cause. He concludes that, in two at least of his cases, the "large pulsating vessels in the pharynx" were due to a tortuous condition of the internal carotids. This possible distribution is illustrated by a specimen in the Museum of Glasgow University in which the internal carotid arteries are bent upon themselves.

The importance of detecting abnormal pulsation of the nature above described is self-evident. Such a distribution of the internal carotid may possibly explain some of the fatal cases of hæmorrhage which have followed the removal of naso-pharyngeal adenoids.—*Practitioner*.

Stab-wound of the Heart: Recovery.—J. Rudis-Jicinsky (*New York Medical Journal* April 23, 1898). The writer's patient was a man aged twenty-six, who received a stab in the precordial region. The wound was clean-cut beneath

the fifth rib, and was situated one-and-a-half inches from the middle of the sternum. It was three inches deep, and penetrated the lung, pericardium, and apex of the heart. There was very marked collapse. Five days later empyema on the left side was diagnosed, and an incision was made in the eighth intercostal space; a large amount of breaking-down blood-clot was evacuated. The discharge continued to be very profuse for a long time, and three months had elapsed from the time of the accident before the man could be considered to be convalescent. Ultimately he made a good recovery.

Fischer, who collected 401 cases of wounds of the heart, found that recovery had taken place in 50 cases. Several cases have also been recorded where patients have survived for considerable periods with foreign bodies lodged in the heart.—*Medical Chronicle*.

Rupture of the Patellar Ligament: Suture: Recovery.—Dr. Macartney (*Lancet*, Sept. 17, p. 754). A man, aged fifty-four, fell on his knee from a ladder. The patella was drawn up the thigh nearly two inches, leaving a hollow at the upper part of the tibia. The patient could not extend the limb, and swelling in and near the joint, was well marked. The limb was fixed temporarily on a splint to allow the effusion to pass away. After a week, a vertical incision was made over and below the patella. The ligament and the capsule of the joint, in its whole breadth, were found torn across. The ragged edges, first of the capsule, then of the ligament, were pared and nipped by continuous catgut suture. Nine days afterwards the wound was healed. Seven weeks after the injury he was able to get up. Complete recovery followed.

Dr. Macartney notes that the rupture was at the patellar end of the ligament and not, as in the majority of cases, near the tibial insertion.

The Treatment of Varix.—Mr. W. H. Bennett (*Lancet*, October 15) observes that there is probably nothing which produces so much harm as the routine use of elastic support, whether stockings or bandages. In 25 per cent. of the cases the troubles are due to the use of unnecessary or ill-fitting supports. In individuals following ordinary occupations, varix which causes no trouble

and has no tendency to increase should be left alone, unless for special reasons operation is indicated. He has seen four cases of grave thrombosis caused by ill-fitting appliances. In varix confined to the leg the harm done by ill-fitting supports is less than in varix affecting the thigh. He never allows a patient suffering from uncomplicated varix of the thigh to use any support above the knee, because all the comfort obtainable in uncomplicated varix of the lower limb can be afforded by a properly-arranged support which does not extend above the leg. In certain cases of œdema of the whole limb elastic support throughout may be indicated; then the thigh-piece should be distinct from the leg-piece.

Primary Acute Infective Osteomyelitis of the Vertebrae (*Centralbl. f. Chir.*, Leipzig, June 4, 1898, No. 22). There is so little information available on "acute necrosis" of the vertebrae, that considerable interest attaches to a communication, by Riese, to the recent Congress of the Surgeons of Berlin. The condition is diagnosed with difficulty, because the patients tend to become drowsy, the symptoms of general illness overshadow the local lesion, and the internal organs may be simultaneously infected. Hence the condition has been mistaken for meningitis, pneumonia, pleurisy, peritonitis, Landry's paralysis, etc. It may be possible, however, to make a diagnosis from the local signs, especially if the infective inflammation originates in the laminæ, or in the spinous and transverse processes. A characteristic feature is the excessive tenderness of the affected vertebrae on direct pressure, while there is an absence of pain on vertical compression of the spinal column. Suppuration takes place during the first or second week. One should operate at the earliest possible stage. Out of twenty-one published cases, fifteen terminated fatally, and only three made a complete recovery. Riese's experience was based upon four cases; one of these was shown at the Congress.

A previously healthy boy of seventeen had a recent whitlow, when, after carrying a heavy weight, he complained of a severe pain in the sacrum; three days later he could not stand. High fever, retention of urine, œdematous swelling over the lower lumbar vertebrae, excessive tenderness on pressure over the spinous processes, and absence

of pain on compressing the spinal column from the headwere present. Operation was performed on the seventh day from the commencement of the illness. A teaspoonful of greenish yellow pus was obtained from beneath the periosteum of the laminae of the fourth lumbar vertebrae. These laminae and the spinous process were removed by the bone-pliers. The dural sac was punctured, and was found to contain pus; it was incised, and a teaspoonful was evacuated. The retention of urine soon disappeared. Small sequestra were afterwards removed from the laminae of the lumbar vertebrae. The patient was allowed up four months later, and made an excellent recovery. The pus obtained at the operation yielded a pure culture of the staphylococcus pyogenes aureus. The infection is supposed to have originated in the whitlow.—*Edinburgh Med. Jour.*

OBSTETRICS.

Deep Incision of the Cervix in Eclampsia towards the End of Pregnancy.—Dr. Mende (*Therapeut. Monats.*, September, 1898). The general advice given in text-books as to treatment of eclampsia towards the end of pregnancy is that treatment should be expectant rather than vigorous, any interference being liable to start fresh convulsions. Some authorities, therefore, recommend only the use of narcotics and diaphoretics, leaving the rest to nature. Kaltenbach as a last resource advises Cæsarian section. This, however, cannot be well carried out in general practice, especially among the poor, and Dr. Mende advises the employment of Dührssen's method of deep incisions into the cervix to facilitate rapid delivery. He recounts two cases in which satisfactory results followed this procedure. After antiseptic precautions, the uterus is drawn down with hooks, two or three fingers passed into the cervical canal, and deep incisions made in the anterior, posterior, and both lateral walls of the cervix, extending down to the vaginal wall. If the incisions are not carried deep enough at first they can be extended with scissors. The bleeding is inconsiderable. The child is then delivered by forceps or version, and the placenta expressed by Credé's method. In each of Mende's two cases coma with slight convulsions continued for some hours after recovery

from the anæsthetic, but ceased on removal of the tampon applied as after-treatment of the wounded cervix. Dr. Mende advises that in future cases this should not be left *in situ* more than three to six hours.

The Use of Quinine as a Substitute for Ergot in Midwifery.—G. Owen C. Mackness, M.D. (*The Edinburgh Medical Journal*, May, 1898). The advantages of quinine over ergot are its ease of administration in pill form, its stability, its tastelessness (in pill form), and the absence of vomiting. It is more rapid and reliable, and its chief advantage is that it does not produce tetanic contraction of the uterine walls, but merely increases the strength of the labour pains. It is of especial value in simple uterine inertia, and to stimulate flagging pains in a primipara. Here it often obviates the use of the forceps. It should be given in eight-grain doses, repeated in four-grain doses for two successive hours, if necessary. Although not as useful as ergot in post-partum hæmorrhage, it is more useful in hæmorrhages occurring during labour. No symptoms of cinchonism result from its use in this way.—*Internat. Med. Magazine.*

Treatment of the Vomiting of Pregnancy.—Bacon (*American Jour. of the Med. Sci.*, June, 1898) publishes three cases of hypermesis gravidarum where he induced premature labour without curing the vomiting, and which ended fatally. He quotes Cohnstein's statistics, embracing 200 cases, of which 40 per cent. only were cured by abortion. From his experience and from an examination of the literature of the subject, he draws the following conclusions.—(1) The abnormal irritability of the nervous system is to be allayed by keeping the patient in a horizontal position, by attention to the skin, bowels, and kidneys, using rectal and, if necessary, hypodermic injections of normal saline solution. (2) The hysterical condition so often present should be controlled by strengthening the will and influencing the dominant ideas of the patient. (3) All sources of peripheral irritation should be discovered and treated. (4) In extreme cases subcutaneous saline injections serve the threefold purpose of (a)

diluting the blood and raising blood pressure, (b) eliminating toxins through the renal and intestinal emunctories, (c) furnishing two most important kinds of food (chlorides and water). He reports a case in the ninth week of pregnancy and in a desperate condition, where the hypodermic injection of a salt solution twice a day, combined with washing out the stomach every morning and rectal injections of salt solution four times a day, produced immediate improvement. The vomiting ceased after the second injection, and food was retained, though the patient eventually died of tetanus (from an infected hypodermic puncture?). In France Laborie has also used this method with excellent results. (5) Induction of abortion is never indicated. At a stage when it is safe and efficient, it is not necessary, and in extreme cases it adds greatly to the danger, rarely stops the vomiting, and can be substituted by artificial serum.—*Brit. Med. Jour.*

Symphysiotomy.—Lepage (*Annales de Gynécologie*, March, 1898) reports eight symphysiotomies for contracted pelves. In all the degree of contraction was not pronounced, and the cases came within the recognised limit of the operation.

In his first case the child was lost through birth-pressure, the mother making a good recovery. The patient had broken her right thigh when a child, and the pelvis had suffered in consequence. The child perished from pressure upon the cord and pressure during extraction.

His second patient had lost two children by forceps extraction. In the present labour the symphysis was easily opened, the head rotated by Farabeuf's lever, and delivery was spontaneous.

His third case was a face presentation in a woman who had been pregnant eight times and had lost several children by the use of forceps. After symphysiotomy the chin rotated under the pubes, and the child was expelled.

In Case 4 fruitless applications had already been made with forceps before the patient came to the hospital. After symphysiotomy, the head was rotated by the lever and a living child delivered. The mother suffered from incontinence of urine for some time, and was threatened with phlebitis.

In Case 5 the mother had intestinal disorder and pain in one leg after the operation, but mother and child made a good recovery.

In Case 6 the forceps and lever failed to extract the child, and symphysiotomy was finally successful. The child, however, perished. A fracture of the skull was found upon autopsy.

The seventh operation was done upon a woman on whom symphysiotomy had been performed in previous labour. Some difficulty was found in opening the scar-tissue left by the first operation.

The eighth operation was done upon a patient who had a normal pelvis but a very large child. Both made a good recovery.

In the same journal, April, 1898, Pinard reports seven symphysiotomies during the past year. There were ninety-seven patients during this period in whom abnormality of the pelvis was recognised. Of these seventy-seven had spontaneous births. Craniotomy was done in six, and abdominal section in three, the forceps was used in three, and symphysiotomy was done in seven. These cases resemble the preceding. The forceps was used in tentative traction, and this failing, the symphysis was opened. Version was employed in some cases. In several, lacerations of the vaginal wall occurred, which were immediately closed by catgut stitches. Six of the patients had rachitic pelves; one an obliquely contracted pelvis. Two were primiparæ, five multiparæ, and one of these had the operation performed the second time. In three labour was ended by forceps, in four by version. Six women and all the children recovered. One woman died.

The patient who died was a primipara who had albuminuria. The wound was found apparently united but was discovered to be infected. In the peritoneum were found pure cultures of the colon bacillus. In the symphysis and also in the uterus were streptococci, staphylococci, and colon bacilli.—*Amer. Jour. of Med. Sciences.*

Puerperal Laceration of Rectum above Sphincter.—Gmeiner (*Centralbl. f. Gynäk.*, No. 10, 1898) observed a case of this kind in a young primipara aged 21. She had suffered from colpitis. The vertex presented in the first position. The pelvis was capacious, the head came down quickly. Twenty-five minutes after rupture of the membranes a jet of liquor amnii escaped from the anus during every pain. In order to prevent further laceration, which would have involved the perineum, sphincter, and nearly the whole of the

recto-vaginal septum, a free incision was made into the right labium and vaginal wall above it, and delivery immediately followed without any more damage. The child was a male, 6 lbs. 6 oz. in weight, and nearly 20 in. long. The cranium was normal. A deep rent was detected along the right side of the posterior vaginal column reaching almost to the cervix, and in its deepest part were three curious little perforations into the rectum, each large enough to admit a pea, and arranged in a triangular manner, each a finger's breadth from the other. They were closed with catgut; the wide rent in the vaginal mucosa was covered in by deep and superficial catgut sutures; the surgical incision was repaired with interrupted silk sutures. The catheter was needed for five days. At the end of a fortnight the vaginal and rectal wounds were quite healed. The damage which chronic inflammation had inflicted on the vaginal tissue accounted for the laceration happening in a normal labour, where the second stage did not last half an hour. In one of the two other cases recorded where the rectum was lacerated above the sphincter, the head had been fixed in the outlet for twenty-four hours before the laceration occurred (Reignier); in Piering's case, where the prolapsed hand entered the rectum, the patient was a primipara aged 41.—*Brit. Med. Jour.*

Extra-uterine Pregnancy at Full Term.—

Swift (*Boston Med. and Surg. Jour.*, May 12, 1898) reports a case of this rare condition. The patient, aged 34, had been married eighteen months. Last regular menstruation was January 21, 1897. The February period was only a slight show, symptoms of pregnancy beginning at about that time. On March 26 she had a sharp attack of pain in the abdomen. There were no symptoms of collapse, but a good deal of nausea, attributed to the pregnancy. She was first positive of feeling movement in July, and this grew stronger up to November 19, last since which it had entirely ceased. During the two months the movement was said to have been very violent, and she thought the child at times was in convulsions. This movement was perceptible to friends through her clothing, and when lying in bed would cause the bedclothes to move. The foetal heart sounds had been heard from time to time. On November 19 she felt a sudden gush of warm fluid from the vagina; there was no appear-

ance of blood. Throughout the rest of the day there were regular, but not severe, pains. After that all motion of the child ceased and she noticed that she was getting smaller. The breasts became hard, large, and painful, and then gradually subsided. Her doctor diagnosed the death of the child. As there was no sign of labour after a week, he inserted a catheter into the uterus to induce labour. As he did not succeed, Swift was called in to empty the uterus. He diagnosed extra-uterine gestation, with pseudo-labour and death of the child, and advised waiting, to minimise the chances of hæmorrhage from the placenta. On January 3, 1898, he operated. The child was easily delivered; in one place the side of the head was firmly adherent to the sac which was attached to the intestine. The placenta was only attached to the upper edge of the broad ligament. The patient recovered.—*Brit. Med. Jour.*

Hernia into the Umbilical Cord.—Dr.

W. F. Boggess (*Arch. of Pediatrics*, Sept., p. 678) After the birth of the head in a normal labour there was some difficulty in delivering the body, which was due to an umbilical tumour, the size of a large orange. About 4 in. from the umbilicus was a cyst of the cord as large as a hen's egg, and 1 in. above that was another. The cord was ligatured above all these. The first tumour was a hernia into the cord containing all the intestines, pancreas and portion of the spleen, enveloped in Wharton's jelly. The rupture was reduced only a little at a time owing to the difficulty produced by the child crying. A ligature was passed round the cord each time a portion was passed into the abdomen. The child did well.

Early Ligature of the Umbilical Cord.—

Schwald (*Deutsch Med. Wochenschrift*, Sept. 8, 1898) states that the time usually allowed after the birth of the child before tying the umbilical cord is much too short. It should never be tied before pulsation in it has ceased completely, and it has become white and translucent. This happens, not in a few minutes, as most people think, but as a rule in half an hour at the earliest. With badly-breathing children the cord may pulsate for one and a half to three hours. A child weighing 6 lb. should have 158 grammes of blood, but if deprived of the 100 grammes which remains

in the placenta if the cord is ligatured early, it has only 58 grammes of blood. This is easily proved by weighing the child at birth and again after the pulsation in the cord has ceased, and the writer has often observed an increase of weight of from 15 to 118 grammes. Most important of all, the habit of immediate ligature of the cord, in cases where the child is born apparently dead, in order to facilitate artificial respiration, must be given up, as it is precisely in such cases that a sufficient quantity of blood to stimulate the respiratory centre and lungs is absolutely necessary. Dr. Schowald believes that many still-births, many cases of anæmia, many deaths in the first few years of life, and most cases of so-called congenital heart disease could be prevented by never tying a cord till after pulsation has ceased.

The Physiological Action of Ergot.—Dr. William Murrell (*Medical Press and Circular*, Sept. 28, p. 342) thinks that there is very little doubt that ergot is not an abortifacient. Evidence shows that it aids the expulsion of the contents of the uterus when once labour has commenced, but is powerless to start the process. It has long been the custom of so-called expert witnesses, in cases of criminal abortion, to swear that ergot is an extremely dangerous drug to give to a pregnant woman, but there is absolutely no foundation for the statement. It is a tradition and nothing more.

The Bacteriology of the Vagina and the Etiology of Puerperal Fever (*American Jour. of Obst.*, Sept.).—Whether puerperal fever can result from auto-infection or is always due to infection from without has been hotly debated. The question is to be settled by bacteriology. Prof. J. Whitridge Williams agrees with Koenig that the vaginal secretion does not normally contain pyogenic streptococci or staphylococci aureus, and that puerperal fever is, therefore, due to infection from without and usually to neglect of antiseptic precautions by obstetrician or midwife. He ascribes the positive results of others to faults in technique.

Dr. Williams considers vaginal examination dangerous no matter how carefully done; germs may be introduced. He depends on external examination in all but about a third of his

cases. The external genitals cannot be so easily disinfected as the hands. They should be washed with soap and water, then with alcohol, and then with bichloride solution (1 in 1000). Finally a bichloride pad should be applied. Even then it is impossible to be sure that they are sterile. Vaginal douches he believes to be both useless and injurious. The normal vaginal secretion is bactericidal; the effect of antiseptics is to modify or destroy this property. This is borne out practically, for results are worse in lying-in hospitals when ante-partum douches are used than when they are not.

Gloves for Examining Pregnant Women.—Döderlein (*Centralbl. f. Gynäk.*, Leipzig, 1898, No. 26) while admitting the importance of limiting internal in favour of external examinations, nevertheless thinks that internal examinations are still necessary and recommends the wearing of gloves. He first used those of fine thread, as recommended by Mikulicz and Perthes, but discarded them, as they were permeable, interfered with the sense of touch, and were not smooth enough. The elastic gloves of Wölfler were equally useless, and too expensive when used in large numbers. In the last German Surgical Congress, Friedrich exhibited seamless, thin, india-rubber gloves, which are well suited for making examinations. They are:—(1) impermeable; (2) light, and can be sterilized in steam or boiling water, so that they may be used repeatedly; (3) when moistened with lysol solution, they are smooth as the hand itself; (4) not too expensive for general use. Döderlein has used those for some months in his clinic, and does not hesitate to allow as many as eight students to examine one case, when wearing the gloves. The gloves are kept in lysol solution and before using they are boiled for half-an-hour.—*Edinburgh Med. Jour.*

Extra-uterine Pregnancy: Operation for the Removal of Fœtus after Fourteen Years.—Dr. A. F. Currier, (*American Jour. of Obst.*, Sept., p. 415), reports the following case. A well-developed woman, aged forty-five, had a normal labour twenty-seven years ago, followed by twelve years' sterility. She then became pregnant. On August 2, 1884, she was seized with severe pain, which kept her in bed until October. The

abdominal enlargement gradually diminished. In August, 1897, the abdomen began to enlarge. Examination led to a diagnosis of retained foetus or uterine fibroid. Fistulæ formed, opening into the rectum, and in the left iliac fossa. Laparotomy showed the intestines adherent to each other, and a putrid offensive fluid welling up from the lower abdomen through an opening. The opening was enlarged, and the foetus disclosed. Nothing remained but the bones, almost entirely disarticulated—126 fragments. The patient did well for a time, but died of uræmia ten weeks after operation.

Delivery of Twins after Death of Mother.—Gogotsky (*L'Obstétrique*, March 15, 1898) reports that a primipara, aged 33, was admitted for eclampsia, into the maternity of the University of St. Vladimir, Kieff. Cyanosis and dyspnœa set in two hours after admission, and death appeared imminent. The os was but little dilated; the cervix was therefore incised laterally with scissors. The forceps were applied, but during their use the mother died, and three minutes after her death a slightly asphyxiated child was born. A second child was delivered by podalic version eight minutes after the death of the mother; it was asphyxiated, but readily revived.—*Brit. Med. Jour.*

GYNÆCOLOGY.

Perforation of Uterus by Sound and Curette.—We referred to this accident in our last number, page 30. Rosenfeld (*Centralbl. f. Gynäk.*, No. 11, 1898). A patient, aged 32, with flabby muscles, was about to undergo operation for ruptured perineum. Prochownick, who was the operator, passed a sound cautiously into the uterus; it suddenly slipped in for over 5 in.; no pain followed. Next day he began by using a blunt curette. It also passed in suddenly over 6 in., going into and beyond the uterine cavity. Partial amputation of the cervix was performed, as well as repair of the perineum. In the course of somewhat complicated incisions (Mackenrodt's operation) the body of the uterus was rotated into the vagina. The perforation lay in the posterior wall of the uterus, a little behind the fundus. It was

slit-like, a quarter of an inch long, and its edges were almost clean cut. There was no evidence of peritoneal irritation, but a thimbleful of bloody serum, without clot, escaped from Douglas's pouch. The edges of the wound were carefully united with catgut. No ill consequences followed. Rosenfeld calls attention to Beuttner, Courant, and Odebrecht's three cases of instrumental perforation of the uterus, reported in the 1897 volume of the *Centralblatt für Gynäkologie*.—*Brit. Med. Jour.*

Peculiar condition of the Uterus during the Passage of Instruments.—Bentauer (O.) (*Centralblatt für Gynäkologie*, No. 42, 1897).

ENTRANCE OF THE SOUND INTO A FALLOPIAN TUBE.—Ahlfeld (*Centralblatt für Gynäkologie*, No. 47, 1897).

PERFORATION OF THE UTERUS DURING CURETTAGE.—Courant (*Centralblatt für Gynäkologie*, No. 48, 1898).

Bentauer records two cases in which instruments could be passed into the uterus to a variable depth without being followed by any symptoms suggestive of perforation. In one patient in whom the uterus bimanually was not enlarged, the sound entering $2\frac{3}{4}$ inches, he found that under anæsthesia a dilator could be passed to a depth of six inches. He repeated this observation several times, finally washing out the uterus and packing with gauze. The patient made a rapid recovery, without any bad symptoms. In a second case he found that the dilator entered to a depth of three inches, but a sound was readily passed to a depth of eight inches or more. Bimanually the uterus was not enlarged. Curetting was carried out, and the convalescence was normal.

In these cases he feels assured that no perforation of the uterine wall occurred, but is firmly of opinion that the uterine muscle may relax or become elastic under the pressure of instruments.

Ahlfeld admits that a sound may at times pass into the Fallopian tube if it is abnormally patent, and quotes a case in which this appears to have occurred.

Courant records a case of fibroid uterus in which curetting was performed. The sound during the operation passed to a depth of 9 to 10 in. Hæmorrhage, however, continued to be severe, so it was

decided to perform abdominal section. It was found that a rupture of the posterior wall of the uterus had occurred, and Douglas' pouch contained a considerable quantity of clotted blood. He believes that without the use of undue force the uterus may at times be so softened that perforation may readily occur. This may be brought about after labour by subinvolution or infection. It may also be secondary to constitutional disorders, or tumours, such as fibroids and cancer.—*Med. Chronicle*.

Researches on the Development of Gas in the Uterus.—Lindenthal (*Monatschrift für Geb.*, Band VII., p. 269, 1898). Physometra, which is characterised by the presence of offensive smelling gas in the uterine cavity, is due to the growth of organisms "in utero." Some writers have attributed this to the bacterium coli; others have described a special bacillus. The author has been able to examine the uterine contents in four cases of physometra. He has found a special anærobic bacillus, one of the group of bacillus of œdema, to be constantly present. Twice he also found the bacterium coli, and in one case streptococci and staphylococci.

He also made some experiments on animals with cultures of the bacillus coli and of the anærobic bacillus. The latter is analogous to the bacillus of emphysematous vaginitis, and if a pure culture be inoculated with amniotic fluid gas is produced.

Further, if a culture be introduced into the amniotic cavity of a pregnant bitch an affection analogous to physometra is produced. Hence this bacillus is probably the essential factor in causing this condition. The bacterium coli, on the contrary, does not generally produce gas, although it may do so if the amniotic fluid contains sugar.—*Med. Chronicle*.

Bleeding Fibroid of the Uterus: Ligature of the Uterine Arteries; Arrest of Hæmorrhage and Shrinkage of the Tumour.—Dr. G. E. Herman (*Lancet*, Oct. 22), relates the following case:—A married woman, aged thirty-five, who complained that for three years she had "flooded" at intervals of about three weeks, and for eight weeks had been losing blood continuously, was admitted to hospital. She was remarkably anæmic. A movable tumour, com-

posed of hard, rounded nodules was felt, rising out of the pelvis, and reaching to within three fingers' breadth of the umbilicus. It was continuous with cervix. No tumour projected into the uterine cavity. Operation—either removal of the ovaries, tumour or both—was recommended. She refused any operation which would render her sterile. Dr. Herman therefore tied the uterine arteries through a vaginal incision. A month later no hæmorrhage had occurred, and the uterus could barely be felt above the pubes. She menstruated after the operation once in five or six weeks, and not more copiously than when in good health.

Ligature of the uterine arteries was first proposed and practised by Martin, of Chicago, in 1892, but the results vary so much that Dr. Herman thinks that some of them must be misinterpreted. The benefit of the operation in this case is obvious.

Sarcoma of the Uterus.—Otto von Franqué (*Munchener Med. Wochenschrift*, October 11, 1898) has collected the cases of sarcoma of the uterus in the Würzburg clinic during the last ten years—sixteen in all. He concludes that sarcoma is twenty times less frequent than carcinoma of the whole uterus, and twice as infrequent as carcinoma of the body. Only one-eighth of the cases arose with certainty from the mucous membrane, though this origin is generally said to be the commonest. Thirteen cases began in the uterine wall, and could be divided into varieties similar to myomata (submucous, interstitial, &c.). Of these one was primary and had its origin in the uterine interstitial fibrous tissue, while five certainly, and six probably, began as simple fibro-myomata, but later underwent sarcomatous degeneration. Since there were 361 cases of fibroid tumours observed in the ten years, these figures mean that probably 3·1 per cent. of all myomata undergo sarcomatous degeneration. Three cases were of great interest as examples of the simultaneous presence of sarcoma and carcinoma uteri in the same individual. In one of these after removal of a large fibrosarcoma from the fundus, an adeno-carcinoma was discovered in the stump, the size of a pigeon's egg. In the other two there was early carcinomatous degeneration of the cervical mucous membrane. Two similar cases have been published recently, and Dr. von Franqué thinks such a combination in five cases cannot be fortuitous; either both tumours

have a common cause, or the presence of one favours the growth of the other.

The diagnosis is often difficult. Six cases were thought to be simple fibroids before operation. In seven there was a history of bleeding, beginning again sometime after the menopause, and though this applies equally to carcinoma, if the physical signs are those of myoma, sarcoma must then be suspected. That the symptoms may point exclusively to simple myoma is not of much importance if the tumour is submucous or especially polypous, since the symptoms are urgent in any case. The prognosis is best, therefore, in these varieties. On the other hand, many sarcomata, especially the interstitial, give rise to so few symptoms that the time for successful operation is past when they come under treatment. On this account the writer thinks that sarcomata are not relatively benign compared with carcinomata, as is usually supposed, quite apart from the fact that large sarcomata have a great tendency to septic necrosis. The average age of the patients was 51·6 years, though one was only twenty-seven.

(1) **Torsion of the Pedicle in Ovarian Tumours.**—Chandeleux (*Soc. de Chir. de Lyon*). (Analy. *La Gynécologie*, June, 1898).

(2) **TWIST OF PEDICLE OF OVARIAN TUMOURS.**—Finaz (A.) *Sem. Gynec.*, May 10, 1898.

The changes met with in the tumour vary according to the severity of the twist. In moderate degrees of torsion the veins of the pedicle become pressed upon more than the arteries, thus still allowing blood to enter the tumour. As a result, rapid increase of the cyst occurs, with raised blood tension in the tumour. This is followed by slight hæmorrhage and increase of transudation until the pressure in the cyst approaches that of the arterial tension. This may cause rupture, or be followed by the phenomena of inflammation, ending in suppuration or rupture. If the torsion is very severe, the arteries and veins are both compressed, and from this several results may arise: (1) Progressive ulceration of the pedicle at the point of constriction. This may finally lead to complete separation of the cyst, which floats free in the abdominal cavity, or it may obtain through adhesion enough nutrition to maintain its vitality. (2)

Gangrene of the cyst. This is accompanied by acute general peritonitis, and is generally fatal. (3) Gradual shrinking and atrophy of the tumour, which may even finally disappear. The tumour, if acute torsion be present, shows a hæmorrhagic or pink surface, with a certain amount of surface œdema. This is always accompanied by signs of general peritonitis. Even in early cases, at the time of operation, the serous coat is usually reddened, and shows lymph exudation. Torsion of a cyst may readily bring about intestinal obstruction.

The symptoms usually come on suddenly, with a feeling of something displaced in the abdomen. The pain is at first localised over the affected ovary, but rapidly becomes general, extending into the loins and down the thigh on the affected side. Vomiting is an early symptom; at first it is mucous, later it becomes green. Abdominal respiration is suppressed. There is constipation, often almost complete. The face is usually somewhat drawn and pinched. The pulse is small and quick, and the temperature rises one or two degrees. Death may occur from various causes if speedy help be not given. Thus acute peritonitis may ensue, or hemorrhage into the tumour, which may be followed by rupture.

If the patient survives the acute stage, chronic peritonitis, with the formation of numerous adhesions of the cyst wall to the abdominal viscera, often follows. Sometimes, also, the cyst may suppurate. Intestinal obstruction has been the cause of death in many cases, due to pressure upon or dragging of a loop of bowel.

The diagnosis must be made from rupture of the cyst without torsion, acute intestinal obstruction, hæmatocele, hydronephrosis, and peritonitis due to some other cause.

The only treatment of this grave accident is immediate operation for removal of the tumour as soon as a definite diagnosis can be made. In a few cases, in which the torsion is gradual and the symptoms are subacute, operation may be delayed for a few days.

Torsion is liable to occur during pregnancy, due to the displacement caused by the enlarging uterus, and cases have been recorded of successful operation at all periods of gestation.—*Medical Chronicle*.

NEUROLOGY.**The Etiology of Acute Poliomyelitis.—**

Schultze (*Münchener Med. Wochenschrift*, Sept. 20, 1898), relates a case of a boy, five years old, who was suddenly seized with fever, followed by vomiting, and two days later by paralysis of both arms and of the muscles of the neck. This paralysis began to improve ten days later; in short the symptoms were those of acute anterior poliomyelitis. There were, however, others which occur in acute meningitis; the legs were contracted in a slightly flexed position, there were vomiting, tenderness to pressure at the back of the neck, and high pressure in the cerebro-spinal fluid. This was discovered by a Quincke's puncture between the 3rd and 4th lumbar vertebrae: the escaping fluid spurted out to a height of 500 mm., and 30 c. c. were removed. It was clear, with a specific gravity of 1006, and a trace of albumin and sugar. After a second puncture the symptoms in the legs subsided, and the patellar reflexes returned. As there were no symptoms of a general meningitis, the author supposes that, in this case, there was a more or less localised meningitis in addition to cervical poliomyelitis. Such a combination, according to Schultze, is by no means rare. Micro-organisms may attack the meninges and their vessels alone, or simultaneously the parts supplied by the central artery of the spinal cord. Hitherto it has always been supposed that poliomyelitis and meningitis were distinct diseases, and that in cases of meningitis the grey matter became affected secondarily only if the meningeal inflammation was severe and diffuse. Such, however, is not the case: the symptoms of a localised meningitis may be masked by the paralytic phenomena or *vice versa*. In fact the relations between meningitis and poliomyelitis are those of pleurisy and pneumonia. It is of great interest that in this case the Weichselbaum-Jaeger diplococcus was present in the spinal fluid. This is the commonest cause of cerebro-spinal meningitis, but is not credited generally with being able to set up poliomyelitis as well. Schultze urges that lumbar puncture should be performed in every case of infantile paralysis, as much could be learned from an analysis of the fluid.

Alterations of Taste and Smell in Tabes.—Klippel has made a study of the various

alterations in the senses of smell and taste as they occur in tabes dorsalis (*Arch. de Neurologie*, 1898, and *Journ. de Méd.*, April 10, 1898). Contrary to the general idea he finds that these symptoms are common, and may manifest themselves at a very early date. Thus they correspond to the other sensory symptoms—numbness, paræsthesia, and pains. But they also may occur late. Then anosmia and agustia are observed, and as the patient has, as a rule, many other symptoms to attract his attention, complete loss of smell may go unnoticed. Both these symptoms may appear suddenly and in association with bulbar symptoms. In other instances smell and taste merely show perversion and in an intermittent form, thus resembling crises. There may be for a day or so at a time peculiar earthy, metallic, or bitter taste sensations appearing independently of meals and lasting for about ten minutes or a quarter of an hour. In the same manner patients may complain of sour smells and odours of stale fish, vomited matter, &c.—*Brit. Med. Jour.*

Speedy Relief of Chorea by Bromate of Camphor.—Drs. Bourneville and Katz (*Progrès Médicale*, July 16, p. 35).

A girl, aged 13, in two days developed marked choreic movements, which gradually increased in severity until she had to be put to bed; her rest was disturbed, talking and swallowing were difficult: A cardiac systolic murmur was heard. All the other organs were normal. Camphor monobromate was given in 0.2 gram doses in capsules; starting with two a day and increasing one capsule every other day until nine were given. Such marked improvement was attained that in one week after the medicine had been given the patient was able to sit up. As the movements became less the medicine was reduced, and in about one month the patient was perfectly well.—*Internat. Med. Mag.*

Perforating Ulcer of the Mouth in Tabes.

Letulle (*La Presse Médicale*, April 2nd, 1898) records the case of this rare condition. A man, aged 51, in whom regurgitation of liquids through the right nostril had existed for five months. The teeth had fallen out freely, and the alveolar borders had atrophied. A perforation, involving the

alveolar border and hard palate, lead to the right middle meatus. The perforating area was cone-shaped, and was lined by pale, insensitive, but not ulcerated, mucous membrane. There were some thickening and cicatrisation. Eight cases have been collected by Baudet, who regards the condition as the result of tabetic trophic changes involving the region of the fifth nerve. Syphilis, which existed in most of the cases, may have been the cause. It may easily escape notice; Letulle's patient was not aware of anything. His mouth was examined because of the nasal twang of his voice, and, on being questioned, he remembered that fluids had occasionally come through his right nostril.—*Practitioner*.

DERMATOLOGY.

The Treatment of Ringworm of the Scalp by Chloride of Sodium.—George Steele Perkins, M.D. (*Lancet*, Oct. 22, p. 1058). The following method of treating this obstinate affection, in consequence of its extreme simplicity and the very definite results claimed by the writer, seems worthy of a trial. He says: "For the past fifteen years I have treated every case of ringworm which has come under my care with chloride of sodium, and with complete success in every case. The first case in which I adopted this treatment was a chronic one of five years' standing. The child was well in three weeks and had no return. Many of the cases have been chronic. The method I adopt is the following: Have some chloride of sodium finely powdered and mixed with a little vaseline to make an ointment. The affected part having been shaved, rub the ointment in well night and morning until the place is sore; this takes from two to four days. Then apply some simple application to aid healing. When well from the soreness, the hairs will be found growing healthily and the tinea trichophyton destroyed."

The Pathology of Herpes Zoster: "Aberrant Vesicles."—Herpes zoster should not be regarded as a disease of the skin, but as a manifestation of disease of the nervous system—localised neuritis—which affects usually the posterior root and ganglion of a spinal nerve. But what is the cause of this neuritis? The

etiology of herpes zoster has long been a moot subject. The most satisfactory hypothesis seems to be Landouzy's—that it is of infectious origin. Its definite course, occasional epidemic prevalence, and the immunity conferred by one attack support this view. Moreover, it may occur in known infections—tuberculosis, pneumonia, and syphilis, and (very rarely, it is true) in other exanthemata. In the *Revue de Médecine*, 1891, Adenot published a case in which zona developed in the tract of the radial nerve during measles. In the *Lancet*, December 26, 1896, Dr. Maurice Paul published a case in which an attack of typhoid fever was ushered in by an outbreak of herpes zoster in the segmental area of distribution of the twelfth dorsal nerve. The neuritis probably is a toxic effect, and its localisation doubtless results from a diminished power of resistance of the affected nerve. That a general intoxication can produce this localised effect is proved by cases of arsenical herpes zoster. But the neuritis does not necessarily affect the root and it is not necessarily of infectious origin. Peripheral neuritis of traumatic origin—for example, pressure of an aneurysm on a nerve trunk—may give rise to herpes zoster. The most characteristic feature of herpes zoster is the distribution of the lesions according to cutaneous nerves or nerve roots. At a recent meeting of the Société Médicale des Hôpitaux M. Jeanselme and M. Leredde contributed a paper entitled "The Aberrant Vesicles of Zona." They state that in a number of cases careful examination shows isolated vesicles, disseminated over the entire cutaneous surface, quite similar to those of the zoster eruption. In 1888 M. Boulland published a case, from the practice of M. Brissaud, and in 1893 M. Tenneson carefully studied the subject and stated that if the entire skin of patients affected with typical herpes zoster were examined every day these "aberrant vesicles" would be found nine times out of ten distributed irregularly at great distances from one another on all parts of the body. This statement by a well-known dermatologist is, to say the least, startling, for these vesicles have never been observed, as far as we know, in this country. Though described as similar to the ordinary zona vesicles they do not appear to be usually accompanied by pain, as they remain unnoticed if not looked for. At the next meeting of the society Dr. Giraudeau read notes

of two other cases. A man had well-marked lumbo-femoral zona accompanied by malaise, anorexia, and fever. As the zona portion was completing its development there appeared about thirty lesions over the whole body. Some were small papules, others were excoriated papules, and others were vesicles; some were isolated, and others were united in groups of two or three. There were three or four on the scalp, three or four on the face, ten on the back, and two or three on each upper limb. The erratic eruption was the seat of pains localised to the papules or vesicles but not propagated in the course of the nerves. M. Jeanselme and M. Leredde think that these aberrant vesicles bear out M. Landouzy's hypothesis. They certainly are evidence of the existence of a general and not merely local malady.—*Lancet*, September 24, p. 882.

In the *Lancet*, October 8, a correspondent points out that "aberrant vesicles" have been described in "An unusual case of zona," published by Dr. W. A. Mackay, in the *Glasgow Medical Journal*, October 1897.

The Bacteriology of Noma of the Vulva.

—Freymuth and Petruschky (*Deut. Med. Woch.*, April 14, 1898) report a case in a child aged three years, in which the diphtheria bacillus was found, and which was treated with the serum. The child was admitted on February 2 with recent measles. There was much hoarseness and considerable dyspnoea. On February 5 an extensive noma was observed in the external genitals. Cultivation experiments revealed, besides other microbes, one exactly resembling the diphtheria bacillus. The dysphagia along with the laryngitis, rhinitis, and noma also suggested a mixed infection of measles and diphtheria, and therefore Behring's serum was injected. The child gradually improved, the slough separating from the vulva. It received in all 6,000 immunity units, and made a good recovery. Freymuth states that previous researches have shown noma to be due to various microbes. In the above case it was due to the diphtheria bacillus. Later in the disease exudation was observed on the uvula and palate. Noma was thus successfully treated with antioxin. Freymuth thinks that if a bacteriological examination is made, the number of cases due to the diphtheria bacillus will be found to be considerable.—*Brit. Med. Jour.*

A Peculiar Case of Antipyrin Poisoning.

—Immerwahr (*Berliner Klin. Wochenschrift*, August 22, 1898) reports a case where the eruption affected the mouth and external genitalia. Blaschks and others have seen similar cases, and have insisted on their importance, since they have sometimes been mistaken for syphilis and even treated as such for a long time. A lady, who four years before had been infected with syphilis, but who had been properly treated and had seen no sign of the disease for more than a year, took two doses of $7\frac{1}{2}$ grains of antipyrin on different days for a headache. After the second dose she became feverish, shivered and came out in a urticarial eruption all over her body. Next day the tongue and mucous membrane of the cheeks, palate, lips, and the labia majora were covered with vesicles. These produced erosions, and were so extremely painful that eating was impossible. The patient herself thought she had a relapse of syphilis, but owing to the sudden onset and painfulness of the affection, and because there were no enlarged glands, and the skin eruption rapidly subsided, Immerwahr diagnosed antipyrin poisoning. That this was correct was proved by the cure being complete in ten days with a simple mouth wash and a few aperient pills.

The Exanthemata on Paralyzed Limbs.

—Jolly (*Treatment*, September 22, p. 451), in 1896, reported a case of squamous syphilide on the body and limbs except the right lower limb, which was affected with infantile paralysis. Thibierge also reported a case of rupia affecting all the limbs except the right arm, which had been paralysed since infancy.

Charmeil (*L'Echo Médicale du Nord*, July 25, 1897) reports two similar cases in patients with hemiplegia since infancy. In the first case a papulo-squamous syphilide left the paralyzed limbs entirely free. In the second a tubercular syphilide was abundant on the sound side, but only slightly marked on the paralyzed side. This patient also had a relapsing papulo-squamous syphilide, which had a similar distribution.

Lannois mentions a case of measles in an infant with infantile paralysis of the right lower limb, which was not affected by the rash. Janin de St. Jus described a case of scarlet fever in a young man with hemiplegia. The eruption was at first

confined to the sound side, and afterwards continued to be more marked on this side, although affecting the paralyzed side. Laviart observed the same in a hemiplegia with small-pox. On the other hand Chevalier reported a case of small-pox in a hemiplegia where the paralyzed side was most affected.

Thus there are four cases of syphilis and three of fevers in which the eruption avoided more or less completely paralyzed limbs. Only one observation, Chevalier's, is contradictory.

Several views may be put forward to explain this phenomenon. Unna regards the skin as a good culture ground for the syphilitic microbe, hence the tendency to generalisation of early secondary lesions. In course of time, owing to changes in the skin and vessels, parts of the skin favourable to the development of microbes become more and more rare hence the diminished diffusion of later lesions. In the tertiary stage only certain parts of the skin are vulnerable, and eventually all the skin is immune. According to Unna, syphilides are due, for the most part, to the evolution of the parasite *in situ*, and the cure to structural modifications of the skin and vessels, which place the skin in a condition to resist infection.

OPHTHALMOLOGY.

The Abuse of Cocaine in Ophthalmic Practice.—Dr. Theobald (*Johns Hopkins Hosp. Bull.*) writes a word of warning about the too free use of cocaine in the treatment of diseases of the eye. It is quite common for the general practitioner to use cocaine in eye inflammation, to relieve pain temporarily; it is prescribed in simple catarrhal conjunctivitis. There is no indication for its employment under such circumstances, and it is capable of doing much more harm than good. Because of its pronounced disturbing effect upon the nutrition of the cornea, cocaine is not a remedy to be used carelessly. It dries the cornea to a remarkable degree, and the epithelium becomes loosened, so that it is easily rubbed off, sometimes by the friction of the lids, or from the slightest touch of the instruments used. The field of usefulness for cocaine, apart from its anæsthetic action, is extremely limited. It may be used sometimes to increase the action of other

drugs—for instance, atropine or homatropine will dilate the pupil more quickly and powerfully if combined with cocaine. The solutions should be kept separate; instil the cocaine first and then the atropine. It is also useful as preliminary to the application of astringents or caustics, like the sulphate of copper or nitrate of silver, as it greatly lessens the discomfort.—*Jour. of the Amer. Med. Assoc.*

PHYSIOLOGY.

The Metabolism of the Nucleins under Physiological and Pathological Conditions.—Part I. T. H. Milroy, M.D., and J. Malcolm, M.B. The writers begin with a discussion of the present state of our knowledge regarding the nucleins and their relation to leucocytosis and uric acid excretion. This part of the paper may be recommended to those who wish to become "orientiert" as to the position that research has attained in this important subject. They point out that the administration of nuclein by the mouth has been found to cause leucocytosis. Some contend that this is merely due to the leucocytes passing out of their place of formation into the blood, under the influence of the nuclein, and that after the removal of the latter the leucocytes retreat again (Chemotactic theory). Others maintain that the nuclein causes an increased formation of leucocytes, which is followed by an increased destruction of them. Leucocytes contain much nuclein. If, therefore, they are destroyed, the products of their destruction should appear in the urine. These products are uric acid, oils, allies (alloxur bodies) and phosphoric acid. Previous workers have used the former as the index of increased destruction of leucocytes. The present writers point out the unreliability of such an index, and have used phosphoric acid in place of it. That, indeed, is the original feature in their method of investigation. They set themselves to discover:—

(1) Whether the administration of nuclein by the mouth causes a greater excretion of phosphoric acid than the amount of phosphorus in the nuclein given will account for.

(2) To what constituent of nuclein this is due.

(3) Whether there is a similar increased excretion of phosphoric acid in pathological conditions where leucocytes are in excess.

To a healthy individual, on constant diet, small quantities of nuclein, in the form of thymus tabloids were given. This produced an increase in the excretion of phosphoric acid, both absolutely and relatively to the nitrogen. The increase was considerably greater than would be accounted for by the phosphorus in the thymus. In order to determine which constituent of the nuclein it is that produces the effect, nucleic acid and metaphosphoric acid were given separately, under the same conditions as in the previous experiment. Nucleic acid produced distinct leucocytosis and an increased excretion of phosphoric acid; metaphosphoric acid did not. The writers infer that it is to the former that nuclein owes its power to produce an increased formation of leucocytes, along with an increased destruction of them; the phosphorus that it contained in the destroyed leucocytes appearing in the urine as phosphoric acid.

They then pass to the study of cases of leucocythæmia on the same lines as the above. In this disease they found no increased excretion of phosphoric acid. They conclude, from this, that there is no increased destruction of leucocytes going on in this disease, and that the excess of leucocytes in the blood is probably due to arrested destruction, and not, as in the ordinary leucocytosis, to increased formation. The only difficulty in the way of accepting this conclusion, as the writers admit, that the alloxur bodies (uric acid, &c.), which represent the other moiety of the broken down nuclein of the leucocytes, are undoubtedly present in excess in the urine of leucocythæmic patients. Why these should be increased, and the phosphoric acid not, the writers do not attempt to explain.

This paper may be regarded as an interesting contribution, from the chemical side, to the study of the physiology and pathology of leucocytosis; and we look forward, with interest, to the second part of the paper, which has yet to appear. Whether the influence of nuclein on the leucocytes can be turned to therapeutic uses, is a matter for future investigation; but the administration would certainly seem to be worth trying in some cases where the leucocytes are present in insufficient

numbers, *e.g.*, some cases of splenetic anæmia. The authors mention incidentally that they have failed to confirm the statement of Weintraud—that uric acid is normally present in the fæces. This is of interest to those who are engaged in the determination of the total amount of uric acid excreted in diseased conditions, such as gout.

Absorption of Fat after Ligature of the Biliary and Pancreatic Ducts.—R. H. Cunningham, M.D. The writer seeks to determine whether fat can be absorbed in the absence both of bile and of pancreatic juice. After briefly reviewing the work of previous experimenters, and pointing out the discrepancies in their results, Dr. Cunningham proceeds to describe his own experiments. The bile and pancreatic ducts were tightly ligatured in dogs, and after the animals had fasted for forty hours, 200 c.c. or 120 c.c. of pure or emulsified oils were introduced into the stomach. At the end of twenty hours the animals were killed, and the lacteals and intestinal contents examined. Twenty-two experiments were performed, notes of six of which are given. The results showed that both the plain and emulsified oils had been absorbed to a considerable extent. In order to meet the objection that these results might be due to some pancreatic juice having been left in the intestine at the time of operation, the following crucial experiment was carried out. A loop of intestine was isolated and thoroughly washed out for three days; the oil was then introduced, and the lacteals of the loop examined after eighteen hours. The results clearly showed that natural oils were absorbed. The writer concludes that fat *can* be absorbed in the absence of both bile and pancreatic juice, but very much more slowly than when these are present.

These experiments are of special interest from the corresponding condition produced in the human subject, by cancer of the head of the pancreas obstructing both the bile and pancreatic ducts.

The Salivary Digestion of Starch in Simple and Mixed Diets.—Dr. Aitchison Robertson (*Journal of Anatomy and Physiology*) publishes the results of his experiments to establish whether the digestion of starch is affected favourably or unfavourably by its admixture with other

articles of food; . . . to know which is the more easily digested form of bread; whether it is more easily digested when taken alone, or along with some other article of food or drink; in what form potatoes, rice, &c., are most digestible; and other like questions." The degree to which digestion had taken place was estimated by noting the amount of sugar produced from the substance in the given time. The chief conclusions arrived at after a large number of experiments performed with rice, porridge, bread, and potatoes, under different conditions, are the following:—

1. Porridge and milk is the preparation of oat-meal most easily digested by the saliva.

2. The denser and drier the anylaceous substance is, the more easily it is attacked. Thus spongy bread (*e.g.*, Vienna bread) is more easily digested than the more compact forms; bread and water alone, and new bread, is not less easily digested in the mouth than that which is stale.

3. Milk, tea, and wines retard salivary digestion; coffee and dilute spirits act similarly, but less powerfully; cocoa has hardly any restraining action at all; and beer is actually favourable to the digestion of starch.

The paper contains, also, some observations on the amount of saliva secreted in twenty-four hours—in the case of the writer this was about 400 grammes—and on the action of the various agents that stimulate salivary secretion. Chief of these are hot-water, beer, alcohol, and sugar. Wines do not promote the flow of saliva, while sherry causes a more abundant secretion of mucus.

On the Sequence of Certain Changes in the Urine, produced by Exercise and by Turkish Baths.—E. C. Garratt, M.B. (*Journal of Physiology*, No. 3, vol. 23). The writer's object is to show the order and duration of the chief changes in the urine that result from exercise and profuse sweating. The exercise consisted of bicycle rides of from 40 to 80 miles, at an average speed of $14\frac{1}{2}$ miles an hour. Swan Baths were taken. The diet was not analysed, but was fairly constant. Estimations of the urea, uric acids, phosphates, sulphates, and chlorides in the urine were made for two days before and after the

exercise or baths. The following are the chief conclusions of the writer:—

(1) EFFECTS OF EXERCISE.—The urea, uric acid and phosphates began to increase immediately after the ride. The urea reached a maximum of double the normal amount in twelve hours, and fell to the usual level again in thirty hours. The uric acid rise was less marked, and attained its highest point in six hours; followed by a rapid fall. The rise was more marked when the rider was out of condition. The rise of phosphates was small. An increased out-put of sulphates began during the ride, and attained a maximum of three times the normal in six hours, terminating in twelve to fourteen hours. The chlorides were slightly diminished, probably as the result of sweating.

(2) TURKISH BATHS PRODUCED THE FOLLOWING EFFECTS:—(a) A reduction in the quantity of urine, not entirely prevented by drinking considerable quantities of water. (b) A slight reduction in chlorides. (c) No marked effect on the other ingredients. These experiments confirm the view that muscular exercise is accompanied by a considerable destruction of nitrogenous tissue, and justify the liberal representation of proteids in the diet of training.

The Regeneration of Autonomic Nerves.
—Dr. J. A. Langley. The problem dealt with is, whether efferent cranial autonomic nerves can become connected with the sympathetic nerve-cells of the superior cervical ganglion. To test this, the vagus and cervical sympathetic were divided in cats, and the central end of the former united to the peripheral end of the latter. After some weeks, stimulation of the roots of the vagus produced the same effects as usually follow upon stimulation of the cervical sympathetic. This shows that the vagus fibres had succeeded in establishing connection with the sympathetic ganglion cells. Also that some of the vagus fibres had changed their function. The writer concludes that the function of any of these fibres depends more upon the nerve-cells with which it happens to become connected, than on any peculiarity in the fibre itself.

BOOKS REVIEWED.

OPERATIVE GYNECOLOGY. By Howard A. Kelly, A.B., M.D., Professor of Obstetrics and Gynecology in the Johns Hopkins University. In two volumes, with 24 plates and 590 original illustrations. Pp. 1,112.—New York: D. Appleton & Co., 1898.

The important position occupied by American gynecology cannot be gainsaid. As a surgical authority in this field Howard Kelly holds a place second to none in his own or any other country. This work is not a complete system of operative gynecology but a record of the author's own methods. Thus, he only describes the operations which he recommends—a fact which must enhance the book to those who require a reliable guide. The first volume deals with bacteriology, sepsis, asepsis, antisepsis and the topographical anatomy of the pelvic organs. Then follow gynecological examination, instruments and dressings, anæsthesia, general principles involved in plastic operations. Affections of the urethra, bladder and ureters are subjects which the special investigations and advances made by the author enable him to present in an entirely new manner.

The second volume is devoted entirely to abdominal surgery. General principles, complications and the care of the patient are first treated. Then come tubercular peritonitis, suspension of the uterus, conservative operations on the tubes and ovaries, salpingo-oophorectomy, vaginal drainage for cases where suppuration exists, hysterectomy, ovariectomy. Operations during pregnancy, Cæsarian section, radical cure of hernia, intestinal complications and the more remote results of abdominal operations follow. The book concludes with a chapter on necropsies and the preservation of tissues for microscopical examination.

The illustrations are of unusual excellence, and taken as a whole the work is one of which praise is inadequate and criticism next to impossible.

CHIRURGIE DE L'INTESTIN. Par M. Jeannel, professeur de clinique chirurgicale à la Faculté de médecine de Toulouse, avec 263 figures dans le texte.—Paris: 1898. Institut de bibliographie scientifique. In-8 de 409 pages.—10 fr.

This is essentially a practical work by an author whose contributions to this branch of surgery are important. To mention only some, the compressor of Jeannel, obliteration of artificial anus and colostomy by the methods of Jeannel, may be cited. The work is divided into four parts and displays the methodical arrangement so characteristic of the French authors.

The first deals with general technique—anæsthesia, antisepsis, assistants, instruments, different methods of operating accidents and sequels.

The second part is devoted to operations in the small intestine—puncture, incision, lateral enterorrhaphy, enterostomy, enterectomy, treatment of artificial anus, and fæcal fistula. A chapter is given to each of these subjects and an eighth—on intestinal obstruction and exploratory laparotomy—follows.

The third part deals with operations on the ilio-cæcal region—cæcal colostomy, cæcostomy and resection of the cæcum, resection of the appendix, operations on the ilio-cæcal valve (resection, divulsion, enteroplasty), ilio-cæcal resection (partial or complete), and ilio-colostomy.

The fourth part is occupied with operations on the colon and includes entero-anastomosis, colostomy and colopexy.

TRAITÉ CLINIQUE DE L'ACTINOMYCOSE, PSEUDO-ACTINOMYCOSES ET BOTRYOMYCOSE. Par A. Poncet et L. Bérard, 1 vol. in 8vo. of 410 pages with 45 figures in the text, and 4 coloured plates.—Paris: Masson & Co., 1898.

This remarkable monograph is based on numerous cases of actinomycosis observed by M. Poncet, the leading French authority on this subject. Actinomycosis was unknown in France some years ago, but according to the authors it has now been found in all parts where it has been looked for by clinicians.

A study of clinical forms occupies more than half the volume. The authors describe cervicofacial actinomycosis, acute, sub-acute and chronic, including tempero-maxillary, gingivo-jugal, sub-hyoid, peri-maxillary, peripharyngo-laryngeal, cervical, maxillary, lingual, lachrymal, cranio-cerebral; thoracic, including oesophageal and pulmonary; abdominal of gastro-intestinal origin, actinomycosis of the skin and limbs. They state that the skin is usually affected secondarily; in a number of cases the lesions follow bone disease which may have then disappeared.

A chapter is devoted to pseudo-actinomycoses affections which, in consequence of the presence of yellow granules or other cause, resemble actinomycosis.

The authors dispute the specific powers attributed to iodide of potassium, and think that the successes reported of that remedy are often due to surgical invention; in two thirds of the chronic cases, the result of the iodide treatment seemed to be negative.

TRAITÉ DE CHIRURGIE CLINIQUE ET OPÉRATOIRE. (Publié sous la direction de MM. A. Le Dentu et Pierre Delbet.) Tome sixième; 8vo., pp. 952.—Paris: J. B. Baillière et fils, 1898.

TREATISE ON CLINICAL AND OPERATIVE SURGERY.
(By Le Dentu and Delbet.)

A work which, though still incomplete, has extended to 6 volumes of nearly 1000 pages each, ought certainly to contain everything of importance. But certain subjects—Tumours of the Sternum, of the Thoracic wall, of the Mediastinum, are very incompletely treated. Again, the diagnosis by the Röntgen rays of foreign bodies in the œsophagus receives only eight lines.

The modern surgery of alimentary canal is also very defective in this work, and, moreover, is not free from errors. The treatment of Goitre, on the whole, is good; but though the recent operations of Jaboulay and Jonnesco—resection of the inferior ganglion of the cervical sympathetic for exophthalmic goitre—are mentioned, there is no reference to dangers and difficulties of the operation, and no description which could help a surgeon to carry it out.

A great want in this, as in most French books, is an index. Though containing much of value, this book is on the whole disappointing.

HANDBUCH DER ANATOMIE DES MENSCHEN. Von Prof. Karl von Bardeleben, in Jena. V. Band, II. Abtheilung: 1. Das Aussere Ohr, Von Prof. W. G. Schwalbe, in Strassburg. 2. Mittelohr und Labyrinth, Von Prof. W. F. Siebermann, in Basel.—Jena: Verlag von Gustav Fischer, 1898.

HANDBOOK OF HUMAN ANATOMY. THE EAR. By Karl von Bardeleben.

This work—an example of German minuteness and industry—is of a very high order of merit. The first division of the second part of the fifth volume, on the external ear, by Schwalbe, is illustrated by thirty-five coloured engravings, and is very clear and accurate. The second division, by Siebermann, on the anatomy of the internal ear, consisting of 137 pages, includes the comparative anatomy and the methods of making corrosion preparations of the ear. It is most elaborate, and is made attractive by sixty-six coloured illustrations.

I. HANDATLAS DER HAUTKRANKHEITEN, &c. ATLAS OF DISEASES OF THE SKIN, for students and practitioners. By M. Kaposi. Part I. Acne-Hypertrichosis.—Vienna and Leipzig: Wilhelm Braumüller, 1898.

II. ATLAS DER SYPHILIS, &c. (ATLAS OF SYPHILIS AND VENEREAL DISEASES.) Vol. VI. of Lehmann's Medical Atlases. Second Edition. By Franz Mracek.—Munich: J. F. Lehmann, 1898. Price 14 marks.

It is a pleasant task to review these two books.

Mracek's Atlas is more especially designed for students. The seventy-one coloured plates are each accompanied by a short history of the case in the text. In addition, the concise but clear and complete sketch of the pathology and treatment of venereal diseases will be of the greatest assistance to the student, and will enable the practitioner to renew, and at the same time widen, his knowledge of the subject.

Prof. Kaposi addresses himself more especially to practitioners. He has set himself the task, and, in our opinion, has successfully performed it, of producing before all an aid to diagnosis.

The atlas contains 350 plates, 114 in colours, illustrating both the usual types of skin diseases, and the rarer, but equally important, varieties, and will, therefore, be of the greatest interest and use to those also who have made a special study of the subject.

We may add that both works have been extremely well produced by their respective publishers.

DIE AKROMEGALIE.—VII. Bd., 2 Theil, von Nothnagel's Spezieller Pathologie und Therapie, &c. ACROMEGALY. By Max Sternberg.—Vienna: Alfred Hölder, 1897. Price 4.20 marks.

Sternberg has given us a monograph on a disease which, recognised only twelve years ago, has continued ever since to gather interest in its pathological, and, to some extent, in its therapeutical aspects. It has suggested a number of most engrossing and important questions, and has given rise to continuous discussion.

We must be grateful to the author for having taken upon himself the difficult task of attacking a subject still in such a chaotic condition, and for having carried it out in such a thorough and painstaking manner.

ZUR VERHÜTUNG UND HEILUNG DER CHRONISCHEN LUNGENTUBERCULOSE. (THE PREVENTION AND CURE OF CHRONIC PHTHISIS.) By E. Aufrecht.—Vienna: Hölder, 1898.

In this pamphlet Aufrecht comes forward as an active defender of the theory of the parasitic origin of disease, basing his conclusions on the experimental and clinical experience of many years. He does not believe, however, that tuberculosis is infectious, unless in a given case there is a predisposition to it. As proof he cites the fact that out of the 263 attendants in his hospital not one contracted the disease. Predisposing causes are, therefore, according to his view, of the greatest importance, and must be combatted by attention to hygiene and diet.

An early recognition of the disease is a necessary condition for its successful treatment, and many points are given which, in the author's experience, may render this possible. A warning is given against overdoing out-door exercise, including many of the amusements found at open-air sanatoria.

DIE LUNGENENTZÜNDUNGEN. Nothnagel's spezielle Pathologie und Therapie. Bd. xiv., 2 Theil.

INFLAMMATORY DISEASES OF THE LUNGS. By F. Aufrecht.—Vienna: Alfred Hölder, 1898.

This book in every way fulfils the expectations raised by the author's wide clinical and pathological experience. It contains a mass of important critical observations and valuable statistical information founded on personal experience. The book is written with the greatest clearness, and besides a comprehensive review of the known facts and theories bearing on the subject, many points are discussed and elucidated which have hitherto been too little considered. From such a work it is difficult to pick out any part for special mention, but we can say that the chapter on a typical pneumonia is of absorbing interest, and is splendidly written.

DIE KRANKHEITEN DER FRAUEN. Für Aerzte und Studierende, &c. (THE DISEASES OF WOMEN.) By Heinrich Fritsch. Eighth Edition.—Berlin: Friedrich Wreden, 1897.

This well-known and favourite text-book in its new edition contains an important addition, namely, a chapter on intestinal disorders peculiar to women. The author has been led to do this by the conviction that modern gynaecologists have become too specialised and technical to be good physicians. Both internal medicine and gynaecology would gain by a closer alliance between the two, and the universal laws of therapeutics apply to both. We could wish that in a future edition this new chapter might be still further developed.

DIE ANATOMIE, ETC. (ANATOMY AND TREATMENT OF THE COMPLICATIONS MET WITH IN LABOUR AFTER THE OPERATION OF VENTRIFIXATION.) By Dr. Rühl.—Berlin: S. Karger, 1898. Price 2 marks.

This book is a protest against the indiscriminate performance of ventrifixation, and it is to be hoped it will do something towards opening the eyes of medical men so that they will advise this operation, to which many women have been sacrificed, only after the most careful consideration. Dr. Rühl sets forth most clearly the bad results of ventrifixation in women who may become pregnant,

and demonstrates conclusively that the abnormal condition of the pregnant uterus must result in a definite, but abnormal, mechanism of labour, which in a great number of cases leads of necessity to "accouchement forcé," or even to a serious operation.

OUTLINES OF PRACTICAL HYGIENE. By C. Gilman Currier, M.D. Third edition, revised and enlarged.—New York: E. B. Treat & Co., 1898.

This volume contains all that is required for the teaching of hygiene in schools. It is carefully arranged and all modern discoveries and improvements have been incorporated in the present edition. The principal topics are—soil and climate, clothing, personal hygiene, exercise, school hygiene, occupation, heating, lighting and ventilation, food and diet, water supplies, sewerage, plumbing, garbage disposal, disposal of the dead, bacteriology, disinfection.

THE SURGICAL COMPLICATIONS AND SEQUELS OF TYPHOID FEVER. By William W. Keen, M.D., LL.D., Prof. of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, Philadelphia, &c. Based upon Tables of Seventeen Hundred Cases compiled by the Author and by Thompson S. Westcott, M.D., Instructor in Diseases of Children, University of Pennsylvania, &c. With a Chapter on the Ocular Complications of Typhoid Fever. By George E. de Schweinitz, A.M., M.D., Prof. of Ophthalmology, Jefferson Medical College, &c., and as an Appendix the Toner Lecture, No. V.—Philadelphia: W. B. Saunders, 1898. Pp. 8 to 386. Price, 3 dols.

In 1876, Dr. Keen delivered the Toner lecture on the surgical complications and sequels of the continued fevers, and for the first time collected and discussed all the surgical complications of typhoid fever. To the valuable information there contained is now added that derived from research extending over the twenty-two years which have since elapsed. This appears to be the only work in which these complications, scattered over medical literature in the form of isolated cases are brought together and treated systematically. A fact of great interest is stated in the chapter on the surgical treatment of intestinal perforation—that operations show 19 per cent. of recoveries. The hopelessness of these cases treated medically, makes it the duty of the practitioner to recommend operation in every case where the general condition of the patient does not absolutely contra-indicate it. In this chapter are fully tabulated eighty-three cases subjected to operation. The illustrations in his work are excellent.

BOOKS & MAGAZINES RECEIVED.

BOOKS.

ON THE STUDY OF THE HAND FOR INDICATIONS OF LOCAL AND GENERAL DISEASE. By Edward Blake, M.D., M.R.C.S., with 11 illustrations (H. J. Glaisher); 8vo. Price 2s. 6d.

INFANTILE MORTALITY IN IRELAND. By Patrick Letters, M.D., C.M.

AN ATLAS OF BACTERIOLOGY. By Charles Slater, M.A., M.B., M.R.C.S., Eng., and Edmund J. Spitta, L.R.C.P., Lond., M.R.C.S., Eng. The Scientific Press, Ltd.; 8vo. Price 7s. 6d.

CHIRURGIE DE L'INTESTIN. Par M. Jeannel, avec 263 figures dans le texte.—Paris: 1898. Institut de Bibliographie Scientifique. 1n-8 de 409 pages. 10 fr.

TRAITÉ CLINIQUE DE L'ACTINOMYCOSE, PSEUDO-ACTINOMYCOSES, ET BOTRYOMYCOSE. Par A. Poncet et L. Bérard, one vol. in 8vo. of 410 pages with forty-five figures in the text, and four coloured plates.—Paris: Masson & Co., 1898.

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DIE ANATOMIE, ETC. (ANATOMY AND TREATMENT OF THE COMPLICATIONS MET WITH IN LABOUR AFTER THE OPERATION OF VENTRIFIXATION.) By Dr. Rühl.—Berlin: S. Karger, 1898. Price 2 marks.

MATERIA MEDICA. By Wm. Martindale, F.L.S., F.C.S. Sixty pages with an Index. Tenth Edition.—London: H. K. Lewis. Price 1s. net.

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The Medical & Surgical "Review of Reviews"

A MONTHLY SUMMARY OF THE BEST IN THE MEDICAL AND SURGICAL PERIODICAL
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No. 3.

NOTES.

Lord Lister, in his presidential address at the anniversary meeting of the Royal Society, held on St. Andrew's Day at Burlington House, prefaced his remarks by references to the Fellows and Foreign Members of the Society who had died since the last anniversary meeting. Of Mr. Gladstone, whose gigantic powers were directed more in other lines than those of science, Lord Lister said the Society could not but feel the poorer for the absence of his illustrious name from its list of Fellows; and to Lord Playfair's wisdom and energy he credited the fact that science is taking more nearly its place in the education of the country. By the tragic death of Dr. John Hopkinson (who, with three members of his family, was killed on August 27 by a fall from the Petite Dent de Veisivi) the Society had lost one of its most valued members; an engineer of great distinction, and a physicist whose contributions to science were numerous, highly original, and of far-reaching importance.

On the subject of the plague, Lord Lister referred to the recent sad occurrences at Vienna, and to the appointment, by the Government, of a commission of scientific experts to investigate the epidemic in India. He pointed out that only a few of the medical men and nurses engaged in actual attention on plague-stricken patients have fallen victims to the disease, and said that the idea of any grave danger to the Commissioners should be dismissed. Their chief

duty will be to report upon the evidence already published by various observers as to the nature and modes of transmission of infection. One of the subjects which will engage their attention will be the efficacy of Dr. Haffkine's method of prophylactic inoculation.

Speaking of the rinderpest in South Africa and its treatment, Lord Lister said:—"There is no subject in biology of greater interest at the present time, whether from a scientific or practical point of view, than that of the 'serum therapeutics' of infective diseases." According to a recent report, which bears evidence of authenticity (*vide* "Rinderpest in South Africa," by John Maberley, L.R.C.P., *Lancet*, Nov. 5, 1898), a great success in this direction has lately been achieved. It will be remembered that Mr. Chamberlain consulted the Royal Society some two years ago with regard to the possibility of finding some means of arresting the ravages of rinderpest in South Africa, and that, with the consent of the German Government, Dr. Koch was sent out to South Africa to investigate the subject. The result of Dr. Koch's researches promised, at one time, to effect all that could be desired. But the method of prevention he devised was attended with serious practical inconveniences, and it was ultimately found that it failed to confer permanent immunity. It therefore became necessary to seek for a more perfect method, and the German bacteriologist, Dr. Kolle, went out to continue Dr. Koch's work, in co-operation with Dr. George Turner, the Government Health Officer of Cape Colony.

Dr. Koch had ascertained that the serum of an animal which had recovered from rinderpest, if injected under the skin of a healthy animal, conferred upon it complete, though very transient, immunity. This has been the basis Doctors Kolle and Turner have worked upon, and after a long series of investigations, it would seem that they have, at length, attained success by simultaneously injecting, at two distant parts of the animal's body, a given quantity of antitoxic serum and blood of a diseased animal, which without the serum would prove fatal. As a result of these injections, the beast becomes infected with a modified form of the disease, which only occasionally proves fatal. Less than 1 per cent. of the cattle subjected to this treatment fail to recover, a striking contrast with ordinary rinderpest, which kills from 80 to 90 per cent. of those affected. As in the case of vaccination, this modified and mild form of the disease protects against infection in its most virulent condition. Cattle in which the treatment had produced no symptoms at all, remained absolutely unaffected when tested subsequently with a quantity of infective cultures sufficient to kill 10,000 full-grown oxen. The immunity is also said to be of a lasting character, and so far as experience has yet shown, is quite as effectual as that caused by an ordinary attack of rinderpest.

The process was very extensively employed among the herds during the late epidemic, and with most gratifying results. According to an estimate based on the Cape Government statistics, preventive inoculations carried out during the last two years, including those by Koch's method, have saved the lives of upwards of 700,000 head of cattle; and it is claimed that, if it had not been for these prophylactic measures, the number of cattle remaining in the country would now be but little more than 300,000 instead of upwards of a million. As Lord Lister remarked, we here have a striking example of the beneficent application of science. It should be remem-

bered that these gratifying statistics record the gross results, including not only those of the present improved method, but also those of the comparatively imperfect system which led up to it.

Among the subjects which had come up before the society during the past year, Lord Lister mentioned the striking discoveries in the domain of chemistry—the liquefaction of hydrogen by Professor Dewar, which had led to the remarkable results obtained by Professor Ramsay. The liquefaction of gases had been the means by which Professor Ramsay had discovered what appears to be a new elementary body, to which he has given the name of Krypton, and the production of a new elementary gas with an atomic weight between those of Argon and Helium, to which the name of Neon had been given. As the Argon liquified at the low temperature caused by boiling liquid air, a white solid was seen to be deposited in it which remained after all the liquid air had evaporated. This solid, on being volatilised and tested, has been found to be a new element (?) Though unlike Argon in physical character, it possesses nearly, if not absolutely, identical atomic weight. This new element has therefore been called Metargon.

Lord Lister was re-elected president of the society, and Mr. A. B. Kempe was elected treasurer, in succession to Sir John Evans. Professor Michael Foster and Professor A. W. Rücker were re-elected as secretaries, and Sir Edward Frankland as foreign secretary. The following members of the council were re-elected:—Professor T. G. Bonney, Dr. Jos. Larmor, Professor Nevil Story-Maskelyne, Professor E. B. Poulton, Dr. W. J. Russell, and Mr. Dukinfield H. Scott; the new members of the council being:—Captain Ettrick, W. Creak, R.N., Professor D. J. Cunningham, Professor W. A. Herdman, Mr. Victor Horsley, Sir Andrew Noble, Professor A. Schuster, Dr. G. J. Stoney, and Professor J. J. Thomson.

In appointing a commission of scientific experts to investigate and report on the plague in India, the Government has adopted a course that will give general satisfaction. Dr. Thomas R. Fraser, of the University of Edinburgh, is President of the Commission, and as Dr. Fraser has already had a considerable Indian experience, his selection would seem to be eminently suitable in every respect. Dr. Wright, Dr. A. L. Amröth, Professor of Pathology at the Army Medical School at Netley; Dr. Armand Rüffer, late head of the Egyptian Sanitary Department at Cairo; and two officers of the Indian Civil Service who have had large experience in India, will serve on the Commission. Dr. Wright has, for years past, been studying the treatment of diphtheria, typhoid, and Malta fever by inoculation. The character of the members of the Commission will doubtless ensure the confidence of the educated classes in India. The prejudices of the less-enlightened natives against preventive measures will be more difficult to overcome. The inquiry will be directed to the discovery of the chief causes of infection and to the practicability of inoculation. In both directions the field is wide and prolific of possibilities.

In India the plague continues to decline the returns for November showing a general improvement; but the reported outbreak of the bubonic plague in Madagascar has been confirmed. The Colonial Ministry at Paris admit that a number of cases have been reported at Antananarivo, and telegraphic orders have been sent to General Galleni to instruct his medical staff to take all necessary precautions to localise the disease. Orders have been given to cremate those who die, and to "placard" medical advice. The news of the plague at Antananarivo unfortunately coincides with the announcement that certain of the Messageries steamers plying between Marseilles and Durban, in the colony of Natal will, in the future, make longer stays than heretofore at Majurga, Tamatave, and

Diego Saurez. It is to be hoped that the authorities at Marseilles and Durban will exercise every precaution. The French Colonial Office reports that, so far, only natives have been attacked. The latest advices tend to show that the outbreak is far more serious than was at first supposed, and the authorities at the Mauritius and the Cape are taking energetic precautions—rigorous quarantine measures will be enforced.

The Austrian Medical Commissioners, who visited Bombay last year to study the plague, and whose experiments have had such disastrous results at Vienna, have prepared a valuable report on the disease. They record the fact that the first symptoms may present the appearance of pneumonia, without glandular swellings. The pulmonary form cannot, at first, be easily diagnosed. It was this circumstance that led to the death of Dr. Müller. When Barisch contracted the disease at the laboratory of the Pathological Institute Dr. Müller at first treated him for influenza. With the pneumonic type, it is sometimes impossible to determine the cause of death until a necropsy has been held. Griesinger's opinion that an early appearance of glandular swellings and superficial carbuncles evidence a mild attack is claimed to be erroneous. There are fatal cases in which no swelling of the glands can be detected by palpation, though a post-mortem always reveals glandular swelling, if only slight; and many cases have recovered in which the first symptoms were not bubonic. Where death occurs in bubonic cases before the disease has become general through the system, Dr. Müller suggested that there may be infective intoxication produced from the secretions of the primary bubo. Clinical observations led to the conclusion that the disease originates in an infection through the skin, which, for a time, remains localised; operation is not advised. Whether the patient recovers or not depends largely upon his natural power of resistance to the specific poison.

In the *British Medical Journal* of Nov. 5, Dr. Gordon Sharp, of Leeds, gives the following interesting account of the manner in which an heroic Derbyshire clergyman fought the plague in the seventeenth century:—The village of Eyam, sometimes called the "plague village," is six miles north of Bakewell, and twelve miles from Sheffield. On September 2 or 3, 1665, a tailor received from London a parcel of cloth patterns, together with some old clothes. He was shortly afterwards seized with a sickness, showing the well-known symptoms of bubonic plague. He died on the third day. At the end of the year, forty-four of the inhabitants of the village had died of the disease; and during the first five months of 1666 thirty others died from the same cause. In June the epidemic became more general. The vicar of Eyam, William Mompesson, bravely remained at his post, visiting the sick and burying the dead.

When the epidemic became more violent in June, his wife besought him to leave the place, but he refused to do so. Moreover, he induced the villagers who wished to leave to follow his example and remain, by pointing out to them that they would carry the disease with them, and become a source of danger wherever they went. At the same time he wrote to the Duke of Devonshire, stating that the people would stay at Eyam if they were supplied with the necessities of life. Arrangements were accordingly made that supplies should be left at regular intervals at a certain spot, a signal to be given when they were placed there. The good vicar, perceiving the danger of allowing the people to collect in church in warm weather, conducted the service outside, and preached from a limestone platform. The disease continued to rage throughout July and August, and in the latter month the vicar's devoted wife fell a victim. Mompesson tried

all the cordials and antidotes then recommended for the disease, but without avail. He therefore told the people to burn all their clothing, furniture, and everything else that might become a source of infection; and he set them an example by destroying his own effects. In October the disease began to subside, the last victim dying on October 11, 1666. Though 259 out of the 350 inhabitants of the village had perished, the vicar's courageous fight was successful, as he prevented the disease from spreading beyond the village—an early proof of the importance of isolation.

Tuberculosis and its prevention continue to receive a large share of public attention. Sir Richard Thorne, in his Harben lectures, has discussed the question of administrative measures for the control of tuberculosis, compulsory notification, and Government control of milk supplies in relation to tuberculosis in man. Though there has been an immense reduction during the last half-century in the death-rate from the various forms of tuberculosis, notably phthisis, as a result of improved sanitation, the death-rates from *tabes mesenterica* have increased to an alarming extent amongst children, due doubtless to the larger consumption of cows' milk as food. With regard to the question of compulsory notification of phthisis, Sir Richard's views are at variance with those of many distinguished authorities on public health, who strongly advise that phthisis should be added to the list of infectious diseases now included in the Infectious Diseases (Notification) Act of 1889. He holds that the Notification Act was passed in order to enable the authorities to control the movements of persons who, for a few weeks only of their lives, were in a condition that constituted a danger to the public health; and he does not believe that such control should be made applicable to phthisical patients, who often are not only quite capable of continuing their daily avocations,

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but are generally under the necessity of maintaining themselves and their families as well. He considers that a system of inspection by sanitary officials would lead to publicity and the loss of employment, with the consequent deprivation of the food and comforts so essential to the cure of the disease in its incipient stage; and also that it would largely prevent tuberculous subjects from seeking medical advice when most needful, and thus defeat the main object in view. The Notification Act has not been in force in New York for a sufficient length of time to justify a final conclusion upon such an important matter; but it may be stated that the Academy of Medicine in Paris reported adversely upon a similar measure the committee appointed to consider the question advising the rejection of the proposed system of compulsory notification on the ground that it would probably do more harm than good. Sir Richard said the conclusion arrived at did not justify inaction as regards a disease which still caused over 40,000 deaths every year in England and Wales, and which is widely spread by means of highly-infective sputa. He is of the opinion that at present the best that can be done is to educate the public up to a proper understanding of the importance of preventive measures, and considers that that duty largely devolves upon the medical practitioners to whom phthisical patients go for advice: action for the present to be under a voluntary and not a compulsory system. He appealed to all physicians to give their advice in some such simple form as that found in the leaflets distributed to the out-patients of some of the metropolitan hospitals. The construction of sanatoria out of the public funds for the temporary isolation of persons suffering from phthisis, and the systematic inspection of food supplies, dairies, and cow-sheds were advised. We think Sir Richard's attitude towards the question is to be regretted. The apathy and ignorance of the

many, and the follies of the "conscientious objectors" as a class, cannot be overcome by educational measures and advice only. The effect of the Vaccination Act affords daily proof of this, and if any large degree of success is to be attained, a compulsory system will be found necessary.

Dr. W. H. Ray, Chief Inspector in England for the United States Department of Agriculture, has notified the Press that "All live cattle and every quarter of dressed beef exported from the United States to Great Britain is thoroughly inspected, before it is shipped, by competent veterinarians employed by the National Government. The live cattle are inspected at the different stockyards through which they pass, in some cases three different times before they reach the seaboard, and all dressed beef is inspected at the time of slaughter at the different abattoirs. The live cattle are again inspected on their arrival from the United States at the foreign cattle markets of Great Britain by veterinarians appointed by the Board of Agriculture." Dr. Ray claims that it is impossible for any diseased cattle or diseased dressed beef to escape notice.

For years the difficult subject of how to deal effectively with members of the profession convicted of unprofessional conduct has been under consideration at various times. At present only a very few of the Universities have the power to deprive their graduates of their diplomas, no matter how grave the offence they may have been convicted of. At the last General Medical Council a bill was drafted, the general effect of which is to prevent the holder of a medical diploma or degree from using his medical title after his name had been removed from from the Register, under Section 29 — the penal section—of the Medical Act of 1858. A draft of a proposed bill, and the views of the General Medical Council on the subject, have been presented to the President of the Privy

Council, with whom the General Medical Council acts in the administration of the Medical Acts. In the meantime, steps are being taken to ascertain whether the Universities concerned are likely to support, or oppose, the suggested legislation.

Mr. Edmond Owen made an interesting announcement, in the course of his address before the Medical Society of London, when he mentioned the fact that, in the library of the Medical Society, there are some fifteen M.S. volumes representing the diary, or common-place book, of the Rev. John Ward, who was vicar of Stratford-on-Avon from 1662 to 1681. Mr. Ward combined the profession of divinity with that of medicine, a custom not unusual at that time. The references to Shakespeare in the diary are of great importance, as it is highly probable that the vicar knew the dramatist, at least distantly, although the stage was not then regarded with favour by the church. One of the entries in the diary is as follows:—"I have heard that Mr. Shakespear was a natural wit, without any art at all; hee frequented the plays all his younger time, but in his elder days lived at Stratford, and supplied the stage with two plays every year, and for that had an allowance so large that hee spends at the rate of about £1,000 a year." Another entry runs:—"Shakespear, Drayton, and Ben Jonson had a merry meeting, and it seems drank too hard, for Shakespear died of a feavour there contracted."

The "conscientious objector" is receiving but scant consideration at the hands of the authorities in Cuba, at least in the Holgoín district. The medical relief expedition under the command of Captain R. S. Woodson, a surgeon in the regular army, has been authorised by General Wood to vaccinate every man, woman, and child in the district, and to use force if it is found necessary. Captain Woodson is accompanied by Drs. Meyer Hermann, W. O. Stone, John Dolz, and

Felipe Veranis, who will assist in stamping out the small-pox epidemic. Dr. Veranis was chief surgeon of General Garcia's corps in the Cuban Army, and volunteered to accompany Captain Woodson. A hospital containing 1,000 cots will be established at Holgoín, another, containing 500 cots, at Gibara. Medical supplies sufficient to last for three months have been shipped from Santiago de Cuba. The towns will be divided into military districts, which will be placed in charge of Americans, with Cuban physicians under them.

The long succession of public scandals in France has largely prejudiced the public in this country against French officials as a class; but, to be just, they are not always negligent of the public weal. M. Krantz, the French Minister of Public Works, has recently given orders that henceforward there shall be placed in all trains, and in all railway stations, an adequate supply of medical and surgical appliances and medicaments, to be used in case of accidents. The necessity for this step was forced upon the attention of the authorities particularly by the recent accident near the Gare du Nord, where, almost at the station itself, the wounded endured unnecessary tortures for the want of sufficient appliances and comforts. The authorities in this country will do well to follow M. Krantz's example.

A German statistician, Herr Prinzing, has recently published some interesting statistics in regard to the longevity of married men. After careful research amongst insurance papers, records of hospitals and lunatic asylums, Herr Prinzing has discovered that the mortality among male celibates between the ages of 35 and 40 is much greater than that among married men. He states that the mortality of Catholic priests is double in proportion to that of Protestant clergymen, and that diseases of the stomach and paralysis prevail much more largely among celibates. Suicides are also much more frequent amongst

the unmarried. Herr Prinzing claims that all the higher virtues are more often found in married men, and that they face the world and its troubles more bravely. Briefly, he decides that statistics prove that marriage prolongs men's lives. He makes no reference to the effect of marriage upon women.

The Government Commission on tuberculosis has issued its report, and recommends that in all towns and boroughs in Great Britain and Ireland powers be conferred on the authorities to order, where a public slaughter-house has been provided, that no other place, after a period of three years, shall be used for that purpose; that meat slaughtered elsewhere than in the public slaughter-house shall be inspected, and that the inspectors shall stamp all meats passed as sound. In London the Committee advise public, in substitution for private, slaughter-houses. It has also recommended that no one shall be allowed to offer for sale the meat of any animal not killed in a duly licensed abattoir.

Dr. A. Woblewski, a German chemist, finds from the result of his experiments, to ascertain the effects of sterilisation upon the chief constituents of milk, that the milk, though more or less altered in taste and colour by being sterilised, it is not rendered less favourable to digestion. A very small amount of lactic acid is formed, the albumin is coagulated, and the casein partially precipitated. Pasteurisation acts in a similar manner, but to a less extent.

Sydenham declared that to die of gout is not to die the death of a dolt; and a Parisian journalist, having observed and learned from experience that fashionable persons who suffer from gout and rheumatism delight in discussing their maladies, has come to the conclusion that this idiosyncrasy should be turned to profitable account. To give

practical effect to his opinion, he has started a magazine called the *Revue des Rhéumatisants*, the first number of which has just appeared. As set forth in the motto of this original publication, its object is "to amuse, and, if need be, cure" the sufferers to whom it is addressed. Among the contributors are François Coppée, Aurélien Scholl, Armand Silvestre, Léon Daudet, Marcel Prévost, Forain—whose contempt for things mundane is now, perhaps, explained—and Caran d'Ache. A special feature of the new magazine is to be its correspondence columns. These consultations, whether amateur or professional should be an inexhaustable source—if not of profit—at any rate of entertainment.

At the Camera Club, on the 28th ult., Dr. Beevor showed, in lantern form, the most interesting of his radiograms from cases in the recent Afridi war. It is admittedly difficult to produce lantern slides from radiographic negatives, but Dr. Beevor succeeded in showing that, even under exceedingly adverse conditions, negatives may be taken sufficiently accurate for the surgeon's work, though lacking perhaps in pictorial effect.

Under the presidency of Dr. Mansell Moullin, the Röntgen Society held its annual conversazione on November 21. Several prominent workers gave demonstrations in their special lines, notably Professor Silvanus Thompson's experiments with the Tesla Oscillator, Professor Gladstone's method of testing the grade of rays, and the excellent exhibition of stereoscopic X-ray photos by Dr. Mackenzie Davidson. No conspicuous discovery has attended the past year's work, though there has been a decided advance in technique. A few isolated chest cases, and lupus "cures," have been reported, but apparently the "screen" has not as yet become a necessary part of the physician's equipment.

LOCAL GOVERNMENT AND MEDICAL
OFFICERS.

The indifference of statesmen to the importance of medical influence upon the practical well-being of the community was well exemplified by the provisions of the Local Government Act, 1888. Under this Act, the appointment of Medical Officers of Health to administrative counties was made permissive, instead of, as it should have been, compulsory. The result, as the *Lancet* (Nov. 26), points out, has been that only sixteen out of the fifty-one counties have availed themselves of this permission. The evils of such a system are obvious. Those counties in which a spirit of reform prevails are precisely those which stand least in need of a county officer, the local sanitary authorities, whether urban or rural, being fully alive to their responsibilities. But the other counties, of which Devonshire may be taken as the type, stand sorely in need of the stimulus and guidance of a county officer who could support and strengthen the local officers in their frequent conflicts with the District Councils. And yet it is in such counties that no medical officer has been appointed.

The position of the District M.O.H., whose appointment, fortunately, is compulsory, also presents some curious anomalies, which are certainly not conducive to a due regard for public interest. The rate of his remuneration for responsible and often arduous duties is frequently such as would be rejected with scorn by an unskilled labourer, and he holds his appointment on no greater security of tenure than is dictated by the caprice of the Council which he serves. As a private practitioner his interests, and those of his patients, are bound to conflict more or less seriously with his public duties, which in their turn are apt to lead him into trouble with his medical brethren.

Having regard to the extreme importance of the issues at stake, it is surely time that

some endeavours were made to evolve order out of this chaos, and Legislation on the matter should not be longer delayed. What is wanted, and wanted badly, is a Government Sanitary Service to include sanitary inspectors as well as medical officers working under the control of the Local Government Board, the members of which should be appointed by, and be responsible to, headquarters only.

PROFESSIONAL INFLUENCE :—SCHOOL OF
TROPICAL DISEASES.

Medical men are often charged with neglecting to exercise their legitimate influence upon social and political questions of the day. In so far as the reproach applies to matters which concern primarily the welfare of the profession, as distinct from that of the public, there is doubtless much truth in it. Unauthorised practice, "sweating" of doctors by medical aid societies, hospital abuse, and undercutting continue to bear eloquent testimony to the absence of any cohesion or spirit of legitimate co-operation among those who practise medicine and surgery in this country. *L'union fait la force*, and the strength necessary to put an end to the many grave existing evils and to exercise a beneficent future influence can only be obtained by that legal combination and co-operation which many have laboured so sedulously, and hitherto so fruitlessly, to bring into being. Without indulging in the well-worn and rather contemptible cant about the inherent nobility of all who practise medicine, it must be conceded that it is only in such purely selfish matters as the above that the profession fails to exercise its due influence. When we come to consider such questions as sanitation, preventive measures generally, and the education of the people in all matters relating to health, the evidence of professional influence unselfishly exercised is clear and paramount. It is, for instance, but the merest justice to say that the Public Health Act, 1875, and the various Acts

amending that excellent measure, would in many places have remained an absolute dead letter had it not been for the persistent campaigning of medical men, other than those appointed under the Act, in favour of sanitary reform. Such campaigning has often been in the highest sense altruistic, for apart from the obvious consideration that improvement in sanitation means a decrease in the amount of illness and consequently of professional fees, the mere fact that sanitary reform means an increased local rate is sufficient in too many cases to decide the ignorant and obstinate against having any dealings whatever with a person who advocates such costly new-fangled ideas. The sacrifices which have thus been laid by individual medical men upon the altar of public benefit amount in the aggregate to a great deal more than the profession has ever been credited with, and certainly exceed that which any other profession has made in any cause. These sacrifices have fortunately not been in vain. The influence thereby exercised upon a not too teachable community has transformed the England of last century, groaning beneath the weight of disease and frequent pestilence, into the England of to-day, where the death-rate of the largest cities compares favourably with that of the sunniest clime, and where efficient drainage and refuse disposal, together with pure water and progressive precautions against the spread of disease, reflect themselves in the improved health, happiness, and working capacity increasingly apparent in each succeeding generation. With an insight admittedly rare in such matters among statesmen, Mr. Chamberlain, having apparently recognised the importance of the work done by medical men at home in rescuing the community from preventible diseases, is desirous of encouraging them to turn their attention to similar questions in the tropics. The late Mr. C. H. Pearson, in his instructive book, "National Life and Character," contended that in the lowlands of the tropics

the coloured races are bound to send the white man to the wall, for the reason that the latter cannot live there, much less propagate healthy children. But is this theory true? We think not. We do not believe there is anything in the tropics which of necessity renders them unfit for permanent occupation by men of our race.

Tropical diseases are the only serious difficulties to be overcome. To the activity of these diseases the white man presents what may be termed a virgin soil, and he suffers proportionately. If these diseases can be controlled as we control smallpox, typhus, and diphtheria, there appears to be no reason why the white man should not become thoroughly acclimatised, even in the most forbidding of tropical countries, and there work and propagate his kind with almost the same vigour as the coloured aboriginal.

The proposed School of Tropical Diseases will largely help to determine this question, and it is difficult to over-estimate its importance to the Empire and the English-speaking race in general.

THE FREQUENCY OF CRIMINAL ABORTION.

The facts divulged by the prosecution in the blackmailing case recently before the Mansion House justices reveal the appalling extent to which the crime of procuring abortion is carried on at the present time. Briefly, the charge against the prisoners amounted to this, that they had advertised certain "irresistible female tabules," and other "remedies"; and when a number of women had compromised themselves by purchasing the tell-tale tabules, the prisoners, disguised under a new name and address, and pretending to be "public officials," wrote to their victims threatening them with immediate arrest unless a sum of two guineas was sent at once.

There is nothing very novel in this idea. The significant point is the extraordinary number of women who actually

entered into negotiations with the vendors of the "irresistible" tabules. Incredible as it may seem, it was stated by counsel that over 12,000 women had answered the prisoners' advertisements in less than two years. Remembering that the advertisers of similar alleged remedies are to be counted by dozens in the little local papers of almost every London suburb and every provincial town, it is impossible to avoid the conclusion that there must be some hundreds of thousands of women in England at the present moment seeking, purse in hand, for anything that offers a prospect of relieving them, by unlawful means, from the natural consequences of matrimonial or other relations into which they have entered with open eyes.

One of the worst consequences is that the publication of such advertisements tend to keep alive a delusive belief in the efficacy of so-called abortifacients—a belief as unfounded as it is mischievous. It cannot be too widely known that there are no true abortifacients or ecbolics, such as this class of women dream of—none which act specifically upon a healthy uterus in such a way as to kill or expel the ovum or foetus, unless given to a degree which sets up toxic conditions endangering life. (*See Luff, II., 178.*) In fact it is now held by the best authorities that, with some reservations in favour of ergot, there is no so-called ecbolic which acts otherwise than by causing general poisoning, one result of which may be abortion, but a probable result is the death of the woman. It is therefore obviously incumbent on the medical profession to make this known on every fitting opportunity.

Who are the women that do these things? What are the proportions of rich and poor among them—of married and single? An analysis of the 12,000 victims would be immensely instructive. Most of them, we may assume, are poor and ignorant. But unfortunately the procuring of abortion is by no means confined to the poor and

ignorant. Within the last six months the Old Bailey has witnessed two remarkable trials of medical men for performing illegal operations, resulting in death. One of these—the Collins case—referred to a class generally designated as "fashionable," and called forth from both judge and jury a condemnation so stern and outspoken as to produce a deep impression upon all who heard it. The other case—that of Whitmarsh—dealt with humbler folk, and would have passed with little notice but for the extraordinary contrast it presented to the earlier case of Collins in respect of the verdict and sentence. For while the facts in their legal aspect were almost identical in the two cases, yet in the first case the verdict was "manslaughter" and the sentence seven years penal servitude, while in the second case the verdict was "wilful murder," and the sentence death. In the former case the Attorney-General, Sir Richard Webster, made a bold and successful effort to introduce a modification of the law of murder applicably to cases coming into the category of "constructive" murder, to which belong deaths resulting from unlawful attempts to procure abortion. The jury were told that the law gave to them the option of finding a verdict of manslaughter instead of murder, if they were of opinion that the act which caused death, although in itself felonious, was not necessarily dangerous to life. In the Whitmarsh case, which was twice tried, the judge on both occasions emphatically impressed upon the jury that the law gave them no such option. As it is now admitted that the latter is the correct legal view—that the law knows no such distinction as the Attorney-General wished to make, it is manifest that the old common law doctrine must be modified in the direction indicated by Sir Richard Webster, so as to bring it into harmony with modern sentiment in England, and with modern law as embodied in the penal codes of almost every European country, as well as of the United States.

LEADING ARTICLES.

LANCET, October 29.

**Combined Pleural and Pericardial
Adhesion.**

By FREDERICK TAYLOR, M.D., F.R.C.P.

A woman, aged 42, was admitted to hospital for dyspnœa, cough, and pain in the chest. Four years previous she had scarlatina. Her father and uncle had died of phthisis. The face, legs, and feet were slightly swollen, and there was œdema over the sacrum. The breathing was quiet and shallow. Vocal fremitus was deficient at the right base behind. Both bases were dull behind, and the vesicular murmur was absent. There were fine inspiratory rales at the left base behind, and at both bases in front. The pulse was 96, regular, feeble, and compressible. The cardiac impulse was felt in the fifth space an inch below and half an inch internal to the nipple. There was dyspnœa amounting to orthopnœa. The urine at one time contained no albumin, at another a trace. She became more œdematous, the abdomen increased to 39½ in.—partly from ascites, partly from anasarca, which reached to the angles of the scapulæ. The œdema extended to the upper extremities and face. At both bases there were dulness, deficient entry of air, and rales. Dulness appeared on the left side in front and rales under the clavicle. The temperature was nearly always normal or subnormal. She became drowsy and collapsed, and died five and a half months after admission.

The necropsy showed both pleura and pericardium thickened all over, and tightly adherent; dense, pleuro-pericardial adhesions, and fibrous tissue matting together the structures in the mediastinum, the lungs small, compressed, and airless, except at their apices, the right auricle and ventricle dilated, and bronchiectasis. The peritoneum was thick and opaque

and covered with much recent lymph. The kidneys were normal.

The mere co-existence of adherent pleura and pericardium is common in the Guy's Hospital records: adherent or thickened pleura was found, post-mortem, in nearly one-third of the cases of adherent pericardium but the association was very seldom recognised clinically.

As to the etiology of such cases, pericarditis and pleurisy may result from rheumatism, pneumonia, pyæmia, tuberculosis, scarlatina, and other infections. All such explanations present difficulties in this case. A scarlatinal origin is allowable, but on that supposition it is remarkable that such extensive lesions should not have previously given rise to discomfort.

What is the relation between the symptoms and the lesions? Thickened pleura will account for dulness, but here (like the dulness which so commonly persists after pleural effusion) it was due rather to collapsed lung. Neither could the pleural thickening have much share in producing the œdema; but the collapse of the lung and the bronchiectasis no doubt contributed to the dilatation of the right heart which was the chief cause of the œdema. The dilatation of the heart could be explained by the pericardial adhesions.

From this case and another which he records, and from the literature of the subject, Dr. Taylor draws the following conclusions:—(1) While the combination of pleural and pericardial adhesions is by no means uncommon, a few cases are distinguished by features which render diagnosis somewhat difficult. (2) Some such cases form part of a larger group in which the peritoneum and mediastinal connective tissue are also involved in the inflammatory process. (3) The features referred to are especially, prominence of the signs of past or present pleuritic changes, and insignificance of local evidences of cardiac disease. (4) Such patients, nevertheless, do die, chiefly from the incapacity of the heart, with increasing œdema and ascites,

and this incapacity chiefly arises on the right side. (5) In some cases peritonitis may have an important share in the fatal result. (6) In some cases ascites occurs as an early symptom, and gives rise, with the passive enlargement of the liver, to suspicions of cirrhosis.

LANCET, October 29.

The Prevention of Tuberculosis.

By Sir WILLIAM BROADBENT, F.R.S.

Cows are very subject to tuberculosis, and it is by their milk that children are infected. Milk should be boiled or sterilised. By the use of the tuberculin test and precautions against the introduction of diseased animals, tuberculosis in cattle may be eradicated. Consumptive patients should carry receptacles for expectoration, and the contents should be destroyed, if possible, by burning. In case of death the rooms should be thoroughly disinfected under the supervision of the medical officer of health. Members of susceptible families should live as far as possible in fresh air, day and night, summer and winter. Closely-fitting windows are a delusion; if fresh air cannot come by the window into a room with a fire, it will come under the door from the passage and basement. Fear of a draught thus leads to the most pernicious of draughts—along the floor. Ventilation is of vital importance. Everybody ought to sleep with the window open, and the bedroom ought to be as fresh in the morning as when entered at night. Sir William believes that if everybody slept with open windows the mortality of phthisis would be reduced one-half. There would be fewer coughs and colds too. The construction of houses is of great importance. There ought not to be a dark corner, still less a dark passage; sooner or later these harbour germs. Thus extensive flats and gigantic hotels are a source of danger. He used to be greatly astonished to find tuberculosis in splendid country houses with every advantage of climate, soil, and sur-

roundings, and all the aids to health. At last he found the secret was dark corridors. Excesses of all kinds diminish the constitutional resistance to tuberculosis. Alcohol stupefies phagocytes as well as brains.

As to treatment, a great deal more can be done by the open-air treatment to arrest and cure phthisis than was supposed possible. Consumption can be successfully treated in any part of our islands. What is needed is suitable sanatoria within reach of the large towns. There must be dry soil, southern exposure, protection from east and north, absolute freedom from dust, and, if possible, from fog. The special desiderata are a maximum of sunshine and a minimum of wind and wet. These sanatoria should be so constructed that it is impossible to close the windows of any room, day or night. They need be little more than sleeping sheds. The patient should spend the entire day in the open air, wet or fine, warm or cold. Movable shelters will protect him from cold winds and rain. On no pretext should he sit indoors.

LANCET, November 5.

Acute Necrotic Cellulitis of Both Orbits.

By W. P. HOLMES SPICER.

A healthy lad, aged 16, a bookkeeper in a poultry-shop, had headache on the left side and blocking of the left nostril, on February 5th, and a rigor on the 6th. Swelling of the left eye began on the 8th, and increased rapidly on the 9th, when the temperature was 102° and he became delirious. There was intense dusky congestion of the eyelids and surrounding skin. The eyeball was fixed and so proptosed that the stretched lids scarcely covered it; only perception of light existed. There was offensive discharge from the left nostril and fluctuation above the eyeball. The orbit was opened by a 2-in. incision at its upper and inner part. Deep behind the globe was a collection of fetid pus, containing necrotic fragments. The finger could not

detect bare bone. The orbital cellular tissue was grey and dead, and did not bleed. The pyrexia continued and there was muttering delirium. On the 10th, anti-streptococcic serum was injected without effect. On the 11th, the swelling of the orbit had increased and the wound was gangrenous, and the cornea was opaque. A decayed painful tooth in the upper jaw was removed, and the antrum and nose were explored by Mr. Walsham. No bare bone could be felt except a doubtful point at the root of the middle turbinate bone. The eye was excised. A small surface of bare bone was found at the upper margin of the orbit. On the 15th the temperature reached 107°, and much bare bone could be felt in the orbital roof. On the 16th he had a slight convulsion of the right face. On the 17th the orbital plate of the frontal bone was entirely bare, and there was some œdema of the right eyelids. On the 24th there was great swelling and gangrene of the right lids, proptosis, deep orbital fluctuation, and panophthalmitis. The whole of the lymphatic glands of the right side of the face and neck were swollen and fluctuating. On the 26th the patient died. A necropsy could not be obtained.

What was the mode of infection? The patient's employment suggested infection by some dead animal matter through some wound of the conjunctiva. Examination revealed no wound, but owing to the tense condition of the parts, such could not be excluded. The existence of a primary pyæmic focus elsewhere was negatived. There was nothing to indicate a nasal origin.

Cellulitis, resulting in acute necrosis of both orbits, is not common. Among accessible records there does not appear to be one. The prognosis is serious. Meningitis and thrombosis of the cavernous sinus and pyæmia may result. Septicæmia was supposed to be the cause in some cases, but in only one of these was the primary focus—acute tonsillitis—traced. Free incisions should be made.

LANCET, November 5.

The Treatment of Acute Intestinal Obstruction.

BY FREDERICK TREVES, F.R.C.S.

In fatal acute intestinal obstruction the occlusion of the bowel is not the most serious event. In a really acute case death will occur within seven days. Obstruction of the bowel *per se* is not acutely serious. The intestine may be blocked even for three weeks without alarming symptoms. In acute intestinal obstruction there are three stages. In the first the symptoms are intense abdominal pain, collapse, and vomiting, which are due not to blocking of the bowel, but to a sudden impression on abdominal nerves. They have little or no diagnostic character, and attend all sudden and intensely painful impressions on visceral nerves, and are collectively described as "peritonism." They are symptoms common to a series of intra-abdominal accidents—passage of gall stone, torsion of ovarian tumour, perforation of gastric ulcer, rupture of pericæcal abscess.

In the second stage the symptoms attain more individuality, and depend upon mechanical obstruction of the bowel. The pain is largely due to disordered and futile peristalsis; the absolute constipation and vomiting to blocking of intestine. The character of the vomit shows the introduction of another factor—decomposition of intestinal contents. The odour, for want of a standard of offensiveness, may be called stercoraceous. Fæcal vomiting—the ejection of fæces—Mr. Treves has not seen in acute obstruction. Finally, there is increasing abdominal distension, largely due to inability of the contents to escape, but in great part to vascular changes in the intestine. The most severe case of meteorism of the small intestine that he ever saw was due to thrombosis of the superior mesenteric vein.

In the third stage the symptoms have little to do with obstruction as such; they are due to septicæmia. It is this which makes

operation futile. For example, a middle-aged man had a strangulating band, which was divided forty-eight hours after the onset. A more favourable course could hardly have been conceived, yet the patient died with septic symptoms, and the necropsy showed no breach in the bowel and no peritonitis.

Treatment demands two things—(1) early operation, (2) evacuation of the bowel. The real danger lies in the poisonous material above the obstruction. In all acute cases, in recent years Mr. Treves has brought the most prominent coil to the parietal incision, and evacuated it by a small glass tube. He closed the small artificial anus some weeks later. This practice had reduced his mortality one-half.

THE LANCET, Nov. 19.

Total Extirpation of the Stomach.

By DR. CARL SCHLATTER.

On Sept. 6, 1897, Dr. Schlatter performed the first operation of removing the entire stomach. The patient was a woman aged 56, suffering from carcinoma. The continuity of the digestive tract was maintained by uniting œsophagus and intestine, and the operation was a complete success. The patient gained weight and soon was able to take ordinary food. Physiologically no less than surgically the case is of the greatest importance for it shows that digestion can be completely accomplished without the aid of the stomach. The following are some of her diet lists, January 17 :—Milk, 33 fl. oz. ; coffee without milk, 13 fl. oz. ; 3 rolls ; 3 eggs ; soup, $3\frac{1}{2}$ fl. oz. ; fried sausage, 4 oz. ; stewed apples, 7 oz. ; whortleberries, 3 oz. ; and claret, 7 fl. oz. February 5 :—Milk, $11\frac{1}{2}$ fl. oz. ; 3 rolls ; 3 eggs ; soup, 4 fl. oz. ; sweetbreads, $10\frac{1}{2}$ oz. ; cauliflower, 7 oz. ; and claret, 7 fl. oz. March 4 : Milk, $10\frac{1}{2}$ fl. oz. ; coffee without milk, 7 fl. oz. ; soup, 4 fl. oz. ; roast veal, 4 oz. ; carrots, 14 oz. ; 4 rolls ; and claret, 7 fl. oz.

Microscopical as well as chemical examination showed the fæces perfectly normal.

This case also proves with absolute certainty that the successive stages of the excretion of nitrogen in the urine after food are quite independent of gastric digestion, because removal of the stomach from the digestive tract does not cause the excretion curve to deviate in any way from those which are obtained under normal conditions.

A second case of this operation is published in the *Boston Med. and Surg. Jour.* by Dr. C. B. Brigham, of San Francisco, which was also successful, and which bears out Dr. Schlatter's conclusions.

BRITISH MEDICAL JOURNAL, October 22.

The Treatment of Sclerosis of the Middle Ear by Mechanical Vibration Applied to the Spine.

By DUNDAS GRANT, M.D., F.R.C.S.

The results obtained by Dr. Grant in this hopeless disease are surprising. The method was suggested by the observation that some deaf persons who heard better in a noise heard also better on a bicycle. The improvement is attributed to mechanical vibrations, which his method supplies. He applies an instrument carrying an electric motor to the patient's spine between the shoulders for about five minutes at a sitting. The vibrations should be felt in the head and ears, but the instrument should be held as low down as is compatible with this effect, so that the acoustic stimulation may be as slight as possible.

All the cases were characterised by tuning-fork evidence of middle ear catarrh ; they were gradual in onset, free from considerable narrowing of the Eustachian tube, and had not benefited to any degree by inflation or other tubal treatment. In 10 cases a vast improvement was produced in 3 and a moderate improvement in 3. Dr. Grant attributes the result to indirect massage of the stapedio-vestibular joint.

The following cases are illustrations :—A lady, aged 25, had suffered from deafness

for eleven years, which had developed very insidiously. In both ears Rinne's test was negative; bone conduction was neither increased nor diminished, and she heard much better in a noise or on a vibrating bicycle. Her previous treatment was quite ineffectual. Her hearing power on the right side was for the watch $\frac{6}{60}$, for whispered speech 6 ft.; on the left $\frac{2}{60}$ and 3 ft. Vibrations were applied to the spine twice a day, and better hearing was experienced during and after the vibrations. The treatment was repeated once or twice daily for three weeks. She then heard the watch at the distance of 12 in. on each side, and whispered speech at 10 ft. on the right and 5 ft. on the left.

A woman, aged 37, with sclerosis starting with pregnancy, and worse after each childbirth, improved from $\frac{1}{2}$ in. and "contact" for the watch to $3\frac{1}{2}$ in. and 1 in., and for whispered speech from 7 in. and 3 in. to 6 ft. and 3 ft. This was an exceptionally striking case, typical in its etiology and its symptoms, as well as in its absolutely negative response to Eustachian treatment.

BRITISH MEDICAL JOURNAL, Nov. 5,

p. 1392.

The Treatment of Spina Bifida by "Open Operation," followed by Closure of the Spinal Canal.

By PROFESSOR C. YELVERTON PEARSON,
F.R.C.S.

The usual methods of treating spina bifida are unsatisfactory. Practically, they are protecting the tumour, and Morton's iodo-glycerine injections. The Committee of the Clinical Society reported in favour of the latter, but the mere shrinkage of the tumour so produced is not a cure, and a full report of all the cases would probably show a number of fatalities and failures in the majority. Of late years operative treatment has been coming into vogue, and is advocated by Mr. Mayo Robson. The method employed in

the following case, though in details it may resemble others, is original.

A boy, aged 6, had a lumbo-sacral meningo-myelocoele about the size of an orange. The operation was performed antiseptically. He was placed on the left side, and a longitudinal incision was made along the lateral aspect of the tumour on the right side, which extended down to, but not through, the sac. Hæmorrhage being arrested, the sac was laid open, and the margins were held up so as to retain as much fluid as possible. The cord and nerves were clearly visible *in situ*. The cord and its membranes were carefully separated from the skin in an almost bloodless manner, from above down, and restored to the spinal canal—a sponge being placed in the upper opening of the canal to prevent, as far as could be managed, entrance of blood or leakage of cerebro-spinal fluid. A second incision, similar to the first, meeting it at the extremities, was made, and the intervening elliptical integument and sac were removed. Two lateral flaps of dura mater were separated from the surrounding tissues and united by continuous suture. The periosteum was raised from the inner aspect of the neural arches to provide periosteal flaps, but these were of little avail, as the arches were defective. The rounded margins of the elliptical aponeurotic covering were pared so as to provide freshly-cut surfaces. The skin and subcutaneous tissues having been undermined and retracted, two large deep lateral incisions were made through the aponeuroses of the multifidus and erector spinæ muscles parallel to the spine and at a distance of about an inch from their free margins. The aponeuroses were brought in contact by buried sutures of strong silk, thus providing a complete covering for the spinal canal. The skin flaps were united. For the first few days the patient was lethargic and the bladder and rectum were paralysed, but these symptoms soon passed away. Before operation he could not stand erect, walked with a shuffling gait, and the

knees could not be fully extended owing to rigidity of the hamstrings. Back splints were applied, massage and passive movement were employed, and he was taught to walk. His condition became perfectly satisfactory except that his knees were slightly flexed (from want of attention); he could walk well. The covering of the spinal canal was unyielding and no shield was required.

The writer also operated nine years ago in another case, and believes the operation would have been a success, but, owing to defective asepsis, the child died from arachnitis.

He does not agree with all other authorities that paralysis is a contra-indication of operation, for in this case the child moved the lower limbs freely after operation, though it was never observed to move them before.

BRITISH MEDICAL JOURNAL, Nov. 26.

Coxa Vara.

By SIR THORNLEY STOKER, F.R.C.S.I.

As coxa vara has been so recently described and so little studied a definition will be excused. It is a bending downwards of the femur due to curvature of its neck, so that the head is nearly as low as, or lower than, the top of the great trochanter. The neck is convex upwards and forwards. The deformity is usually due to rickets, and is probably common, though it was only discovered in 1889 by Müller. Hofmeister more fully investigated and named it in 1894. Prof. Ogston, of Aberdeen (*Practitioner*, April, 1896) introduced it to British surgeons. In consequence of the depression of the head of the femur the limb is shortened; in consequence of the convexity of the neck it is everted. Coxa vara is generally unilateral. Osteomalacia is the most usual cause after puberty. Occupation is a factor; those much on their feet are prone to suffer. Softening of the bone from inflammation, tuberculous or simple, has been assigned as a cause. The rhacitic form occurs between the age of 3 and 18.

The symptoms are :—(1) lameness; (2) pain referred to the knee; (3) shortening from $\frac{1}{4}$ to $2\frac{1}{2}$ in.; (4) lessened range of motion of the hip, particularly of abduction; (5) eversion; (6) adduction, but usually no power of trans-adduction. Morbus coxæ is the disease with which coxa vara is most likely to be confounded. These diseases are contrasted in the following table :—

Symptoms and Signs of Coxa Vara.	Symptoms and Signs.	Symptoms and Signs of Morbus Coxæ.
Less marked	Common to Both. Lameness Pain Shortening Eversion Rotation	More marked.
Referred to front of knee		Referred to back or inside of knee.
Present at first With adduction		Not present at first. With early abduction only.
Lessened	Not Common.	Lessened.
No tenderness		Tenderness.
Adduction: no trans-adduction		Abduction in early stage.
No inversion		Inversion in late stage.
Trochanter moves in normal arc		Arc of movement lessened.
No swelling, wasting of thigh, or obliteration of gluteal fold in early stage		Swelling of hip, wasting of thigh, and obliteration of gluteal fold.
"Tailor's" rotation present		"Tailor's" rotation absent.
Thomas's test negative		Thomas's test positive.
Skiagraph shows deformed neck		Skiagraph shows no deformity of neck.

Of the three methods of measurement :—(1) from the anterior superior spine of ilium to patella; (2) the application of Nélaton's line; and (3) of Bryant's triangle, the latter is much the most exact and efficacious. It not only measures shortening better by its vertical side, but by its horizontal side gives an exact comparison of the degree of eversion as contrasted with the opposite limb.

In the early stages the treatment is similar to that of rickets—cod-liver oil, phosphorus, lime salts, iron, suitable feeding. Much walking or standing is to be avoided. A Thomas's splint may be used, but care must be taken not to induce a similar deformity in the sound femur. Osteotomy has been proposed, but cases requiring it must be very uncommon.

MEDICAL CHRONICLE, Sept., p. 407.

Intra-Medullary Tumour of the Spinal Cord.

R. T. WILLIAMSON, M.D., B.S., M.R.C.P.

A married woman, aged 41, was admitted to hospital for paraplegia, on March 20. Three months ago she struck her back, in the dorsal region, against a window-sash. In a few days she began to suffer from pain in the back, which persisted. At times the pain had been very severe. It was situated chiefly "between the shoulders." Sometimes there had been lumbar pain also. A girdle sensation was noticed about two weeks before admission, and also a sensation of "numbness" in the legs. Loss of power in the legs developed on March 16. Two days later bladder symptoms appeared. There was no history of syphilis. The patient was unable to perform any movement of the legs. There was no localised wasting of the legs, and no rigidity. The knee jerks and plantar reflexes were present, but there was no ankle-clonus. There was no pain in the legs, and no tenderness of the muscles. There was complete anæsthesia of the right leg, but only partial anæsthesia of the left. The head and point of a pin were not felt on the lower half of the abdomen, but both were felt about $1\frac{1}{2}$ in. above the umbilicus. The abdominal and epigastric reflexes were absent. There was retention of urine, with dribbling and incontinence of fæces. There was tenderness on percussion of the spine from the fourth to the seventh dorsal vertebra. Rhonchi were heard.

April 4—Slight plantar reflexes were obtained on both sides. The knee jerk was present on the right side, absent on the left. There was no ankle clonus.

April 15—Right knee jerk exceedingly feeble; left, absent. No ankle clonus. Plantar reflexes present. No rigidity of the legs. Marked anæsthesia to tactile and painful impressions on both legs. The breathing gradually became more difficult. The pulse

became more rapid, and numerous small râles were heard on both sides of the chest.

April 17—Pulse, 132; respiration, 34; temperature, 101°. Death occurred on April 20.

The necropsy showed that the spinal cord was distinctly soft and gelatinous in appearance above the level of the eighth dorsal vertebra. On the left side of the cord was an area of myelitis having a longitudinal extent of nearly 1 in. It involved the white matter of the cord in the lateral region, and also the grey matter on the left side. At one point, about the middle of the longitudinal extent of the myelitis, was a small tumour about the size of a small pea, which involved the left posterior horn of grey matter and the adjacent white matter of the lateral column.

The pathological diagnosis rested between a small syphilitic gumma and a solitary tubercle of the cord. There were no tubercles in any other part of the body, whilst there was a strong probability of exposure to the risks of syphilis, and the microscopical appearance was more in favour of a gumma than of tubercle; also in the pia mater the arteries in many sections showed well-marked endarteritis, and the adventitia was infiltrated with round cells. The walls of the smallest vessels were thickened both in the cord and in the meninges, and the vessels were surrounded by a zone of cell infiltration. Above the gumma there were well-marked tracts of ascending secondary degeneration in the posterior columns, and below it tracts of descending degeneration in the lateral columns.

Cases of intra-medullary tumour or gumma of the spinal cord, verified by post-mortem examination, are somewhat rare, and the symptomatology of the case recorded above presents several points of interest. The presence of pain for ten weeks before the onset of the numbness in the legs and paralysis, was a point of diagnostic importance; so also was the steady progress of symptoms, and the fact that the anæsthesia

at first was complete on one leg and only partial on the other.

The diagnosis between intra-medullary and extra-medullary (or meningeal) spinal tumours is a point of great practical importance, since the brilliant results of Professor Horsley and others have shown that meningeal tumours may sometimes be successfully removed by surgical operation. One point of importance in the differential diagnosis is pain. In meningeal tumours, pain and symptoms due to implication of nerve roots are severe, whilst in intra-medullary tumours pain is slight or absent. But to this rule there is one exception, of which the case above forms an interesting example. Dr. Gowers points out that if a growth within the cord should begin in the neighbourhood of the posterior horn, then pain may be pronounced. The history of the case recorded bears out this statement. Pain was the most prominent symptom for ten weeks; at times it was very severe, yet the growth was within the cord; but it involved the left posterior horn of grey matter.

ANNALS OF SURGERY, Oct.

The Mechanical Treatment of Subluxation of the Knee.

Dr. N. W. Shaffer advocates this treatment in preference to an operation, and records a number of very successful cases. It is based on an original view of the mode of production of the displacement. His observations show two facts—(1) In many cases there is an acquired or, perhaps, congenital, lateral mobility of the knee-joint, which increases the normal rotation of the tibia in flexion or extension. (2) In many, if not all, cases there exists an elongated ligamentum patellæ which so modifies the action of the quadriceps muscle upon the tibia that extension and rotation are not synchronous. A simple elongation of the patellar ligament may exist and produce in some cases heat, pain, and swelling, but no true arthritis; in others a

sense of weakness and debility; in others a tendency to outward dislocation of the patella. In all there is greater or less disability under severe or even ordinary use of the joint.

On the other hand, there may be considerable abnormal lateral mobility of the knee without danger of subluxation of the semi-lunar cartilage. It would seem that both conditions are necessary except in cases where an extreme degree of force has been applied. No one seems to have studied this elongation of the ligamentum patellæ, though Hey himself mentions it in his original description. He says, "If there is any difference from its usual appearances, it is that the ligament of the patella appears rather more relaxed than in the sound limb."

Dr. Shaffer publishes eleven cases, with skiagraphs which clearly show the elongation of the ligamentum patellæ. In some the lower end of the patella was tilted up from the trochlea. All were treated by an apparatus which permitted flexion only of the knee, and which stopped extension at the point where it ceased to be comfortable. This point represents absence of strain on the ligaments. The apparatus consists of two rods running the length of the leg and thigh on the outer side, and fixed by straps. On the inner side is a pad which presses against the knee-joint.

The apparatus was modified from time to time to admit of greater extension of the knee. Finally, complete cure resulted; the ligaments became shortened and the patients discarded the apparatus. The results were eminently satisfactory; the patients were enabled to walk, dance, play tennis, and cycle.

HUTCHINSON'S ARCHIVES OF SURGERY,
October.

Spondylitis Deformans in a Cat.

Mr. Hutchinson has already (vol. viii., p. 350) recorded a remarkable case of multiple arthritis deformans in a cat. Not only were

many of the large joints severely affected, and the characteristic conditions produced, but the joints of the spinal column were also extensively involved. An exact counterpart, so far as the spinal column is concerned, has been recorded by Dr. Bricon (*Bull. de la Soc. Anat.*, July, 1884, p. 478). It is an example of multiple exostoses, hyperostoses, and synostoses of the vertebral column, and the bones of the limbs are almost wholly free. It would, therefore, appear to have been a close analogue of what we know as spondylitis deformans in the human subject. In the latter affection, although it is a form of rheumatic gout, the joints of the limbs not uncommonly escape. In this cat the only osteophytic growths on the limbs were two small ones near the trochanters. The ribs, on the contrary, presented many osteophytes. The malady seems to be well known in France, and leads to death by marasmus in months or years. The animal is reduced to a state of rigidity; taken up by the head it can be lifted without bending. Bricon terms it "chat barre de fer."

In Mr. Hutchinson's case, although the osteophytes were numerous and large, and must have greatly diminished the flexibility of the spine, there was no true ankylosis. In Dr. Bricon's case the synostosis was, however, quite complete in a great many of the joints, especially in the cervical region. From the fourth to the tenth vertebræ inclusive no distinction whatever could be observed between the bodies of the vertebræ as seen from before.

This affection, so closely similar to spondylitis deformans in man, would appear to be quite distinct from the ossification of the anterior common ligament of the spine, which is not uncommon in horses and asses. In the latter affection, specimens of which are to be found in all our museums, a riband of dense bone passes down in front of the vertebral bodies and unites them. But there are no true synostoses, nor is there any development of osteophytes.

EDINBURGH MED. JOUR., Nov.

Paralysis of the Sixth and Seventh Cranial Nerves.

By G. A. GIBSON, M.D., D.Sc.

A woman, aged 49, was admitted to hospital for chronic bronchitis. When twelve months old her mother one day noticed a sudden change in her appearance; from that time there was loss of power over the right side of the face.

There was complete paralysis of the right side of the face. Taste was normal. Auditory tests indicated affection of the stapedius muscle. Electrical tests showed that the retrahens aurem and anterior part of the digastric muscle were paralysed. The orbicularis oris was completely paralysed. The right external rectus was also paralysed.

Where was the lesion? In consequence of the paralysis of the orbicularis palpebrarum it must have been nuclear or infra-nuclear. According to the current view (that the orbicularis oris is innervated from the hypoglossal nucleus), it must have been infra-nuclear. In consequence of the preservation of taste it must be above the geniculate ganglion. But paralysis of the sixth nerve must be accounted for. There are two positions in which one lesion might cause both paralyses. An affection of the nucleus of the sixth might involve the fibres of the seventh nerve. Such, though uncommon, is known. It resembles acute anterior polio-myelitis of the cord. Or a lesion may affect both nerves at the base of the brain. The lesion must have been an affection of the sixth nerve of an acute nature, or some meningitic process at the base of the brain.

PEDIATRICS, Nov., p. 443.

Treatment of Hydrocephalus by Intracranial Drainage.

SUTHERLAND and WATSON CHEYNE.

A very interesting paper on this subject was read by the above writers at the last

meeting of the British Medical Association. The method advocated is based on the investigations of Dr. Leonard Hill, who finds that in the subarachnoid space around the brain the pressure of the cerebro-spinal fluid is always equal to the pressure of the blood in the veins. This equilibrium is brought about by the rapid absorption of the cerebro-spinal fluid by the vessels, directly the tension of this fluid becomes greater than that of the blood within them. From this it appeared to follow that, if a free communication were made between the cerebral ventricles and the arachnoid space, the excess of fluid existing in hydrocephalus could be constantly and evenly drained away into the blood system. In order to bring about this result it was necessary to establish a permanent channel between the ventricles and the arachnoid space. This was done by means of a "drain" composed of a bundle of catgut threads, one end of which was passed beneath the membranes, after trephining, the other being pushed through the brain substance into the lateral ventricle—a sufficiently easy proceeding owing to the thinning of the cerebral substance brought about by the distension of the ventricle. The writers report three cases thus treated, the patients being respectively 6 months, 3 months, and 12 months old. In the two first cases very marked diminution in the size of the head occurred, the previously separated bones falling together and ultimately over-riding to a considerable extent, so that the theory upon which the procedure was founded was proved to hold good in this disease. In each of these two cases the side of the head operated upon shrank very much more than the opposite half, showing that no free communication existed between the two lateral ventricles, as would be the case in normal subjects. A second operation on the other side was performed upon the second child. In the third case the drain did not act, and it was found post mortem that one end of it was enclosed by

adhesions at the site of the wound. In this case the child died of measles and bronchopneumonia. In the first two cases there was marked improvement at first, but death ultimately occurred. In cases far advanced restoration of mental power cannot be hoped for, even if the tension is relieved. In the discussion following this paper Dr. Still suggested that a possible source of danger would be the escape of the micro-organisms, to which one form of the disease is due, from the ventricles into the arachnoid space.

PEDIATRICS, Nov., p. 452.

The Micro-Organism of Simple Posterior Basic Meningitis in Infants.

STILL.

It is generally admitted that there exists a simple meningitis in children, apart from the tubercular disease, and from secondary infection from the ear or other centres of suppuration. In nine out of twelve cases of simple basic meningitis on which Dr. Still made post-mortem examinations, he found in the exudation a special form of diplococcus, resembling in appearance the gonococcus. In two of the remaining cases the disease was of longer duration, so that the micro-organisms had probably disappeared owing to lapse of time. In a case operated upon in life, the same organism was found, and cultures were obtained on agar and glycerine-agar. Dr. Still regards it as probably a modification of the organism described by Weichselbaum as the "diplococcus intracellularis." The possibility of recovery from the simple form of meningitis seems demonstrated by a case in which a child of eleven months suffered from the usual symptoms of basic meningitis, but improved greatly, only to die, however, of tubercular disease. At the post-mortem examination some thickening of the membranes and adhesion at the base were found, but no active meningitis. The case would previously have been regarded in all pro-

bability, as tubercular meningitis, owing to the generalised disease, but fortunately cultures from the cerebral ventricles had been made at a previous operation. The diplococcus above described was found in practically pure culture.

AMERICAN JOUR. OF MED. SCIENCES,
Nov., p. 503.

Resection of the Gasserian Ganglion.

By Prof. W. W. KEEN, M.D., LL.D.

Dr. Keen has done 11 operations for removal of the Gasserian ganglion of which 10 were secondary, multiple peripheral operations having been previously performed. In one case the removal of the ganglion was the fourteenth operation on the patient. All the cases were operated upon by the Hartley-Krause method; 3 were fatal, 1 from infection, 2 from shock.

The mortality of the operation in 108 cases collected by Tiffany was 22 per cent., but Dr. Keen does not doubt that modern antiseptic methods will reduce it. But it is a formidable operation which even now he approaches with hesitation.

What are the result as to cure? There have been only 4 cases in which the pain has returned; 2 were his own cases, and were his first two operations, and must, he thinks, have been imperfectly done. It can be concluded from over 100 resections that pain will not return in over 1 or 2 per cent. with any severity, like the original, and not in any degree in more than 4 or 5 per cent. The uncertainty of total resection having been done in some of these cases probably makes the percentage too high. If the sensory root of the ganglion be diseased, excision will not be an absolute preventive. There appear to be only two cases in which the sensory root was examined. In one (Krause's), the root was diseased, and pain returned on the opposite side. In the other (Dr. Keen's), though the ganglion showed intense lesions and the

disease had existed for five years the sensory root was intact.

To what extent should the ganglion be removed? Tiffany says that the motor root ought to be saved. In some cases, although Dr. Keen made no attempt to save the motor root, the muscles of mastication were not wholly paralysed, and when they were the patient could readily masticate with those on the other side. But it is anatomically impossible to preserve the motor root. The whole ganglion should be removed. Effects on the eye can be obviated.

Resection should not be performed primarily, but after peripheral operations, as the ganglion appears to be the last to suffer in disease of the fifth nerve. In a case of primary resection the effects on the ganglion after eighteen years of suffering were very slight. But the peripheral operation should be done early. Most operations are done from two to twenty years after the onset. If after three or four months' treatment drugs have only relieved, the peripheral operation should be done in the hope of arresting the disease in its course towards the ganglion.

Pathological report on seven ganglia removed, by Dr. Spiller.—In the more advanced cases of neuralgia there were found much swollen medullary sheaths, swollen axis cylinders, atrophied fibres, empty nerve sheaths, nerve bundles with the nerve elements replaced by connective tissue, atrophied ganglion cells, and sclerosed vessels.

AMERICAN JOUR. OF OBST., Oct.

Rupture of the Symphysis Pubis during Labour.

By JOSEPH B. LEE, M.D.

Spontaneous rupture of pelvic joints during labour is rare, during operative delivery it is more common. The joint most often affected is the symphysis pubis, but if the widening be great, one or both sacro-iliac articulations must give way also. The normal softening of the articulations during pregnancy is a

predisposing cause of rupture. A generally contracted pelvis or a large child favours it. The forceps has caused 67 per cent.; ill-direction of the handles during traction may be responsible.

Symptoms.—Where there has been relaxation of joints during pregnancy, the symptoms of this condition—pain and difficulty of locomotion—have been present. But rupture does not always occur with relaxation; on the contrary, it sometimes facilitates labour. Eldridge relates an instance where, during labour, two fingers could be placed in the joint. Cure was perfect after several weeks. During normal labour there may be no symptom of rupture for several hours. But sometimes the woman feels something giving way, or a cracking or tearing noise may be heard. When the pubis has given way during a forceps operation, the resistance suddenly disappears. There may be hæmorrhage if there is a coincident vaginal tear. Pubic pain is a prominent symptom. Every movement is painful. If a sacro-iliac joint has been over-stretched, there is pain on that side. But, singularly, pain may be absent for the first few days or begin only when the patient moves about. There is great pubic tenderness. The attitude is characteristic: the patient lies on her back, helpless, the legs are abducted and rotated outwards. The bladder is affected in a few cases; there may be urethral or vesical fistulæ and resulting incontinence, but the latter may occur from tearing of nerves around the neck of the bladder only. Since retention is more common after labour, this incontinence should always excite suspicion of pelvic lesion.

The course varies. If the tear is uncomplicated the joint unites again; if it communicates with the vagina suppuration is the rule. Sometimes a sequestrum comes away, and if there is good drainage the wound granulates; otherwise burrowing abscesses and perhaps general sepsis result. When no communication with the vagina exists, the joint may suppurate, being infected through lymph

channels or through the blood when there is general sepsis. Infection is signalled by chill and rise of temperature. There is pain and swelling of the mons. Pus forms rapidly and fills the connective tissue around the joint, pushing bladder and uterus backwards, urethra downwards, peritoneum upwards, and mons forwards. It may burrow in any direction, it may infect the sacro-iliac joint. If there is early exit or drainage the patient usually recovers; otherwise general infection may occur.

Where the joint has not been infected, union is usually complete in from three to six weeks. Some unsteadiness in gait may be observed for longer or shorter periods. Union is usually fibrous, seldom osseous. Sometimes the pelvis has remained permanently enlarged, the space being bridged over by fibrous tissue, and the following labours being rendered normal. Operators have sought to imitate this by osteoplastic symphyseotomies.

Treatment.—If relaxation of the pelvis during pregnancy is annoying, a pelvic girdle will give relief. After rupture the same treatment applies. If the joint becomes infected, drainage should be provided, each abscess should be opened as soon as possible. In obstinate cases of non-union the joint may be wired or nailed. If labour is difficult subsequently symphyseotomy may be done; if a large callus prevent delivery, Cæsarian section or craniotomy may have to be considered.

AMERICAN JOUR. OF OBST., Oct.

Oöphrectomy for Rudimentary Uterus. Absence of Vaginal Menstrual Molimina.

By H. N. VINEBERG, M.D.

A domestic, aged 20, was seen for non-appearance of menstruation. At 15 she began to suffer from vague pains in the lower abdomen and pelvis; they occurred every four weeks, and lasted three or four days. The attacks became more frequent and severe; they recurred every two or three

weeks, and lasted five to seven days, compelling the patient to keep in bed. The external genitals were normal; the vagina was completely absent. Recto-abdominal examination showed bodies supposed to be ovaries, but only an indistinct resistance in the position of the uterus. Laparotomy was performed to remove the ovaries and relieve the menstrual molimina. The ovaries were found with difficulty; the left lay on the pelvic brim; the right near the vertebral column at the umbilical level, so that the abdominal incision had to be prolonged to the umbilicus before it could be brought into view. The patient recovered, and had been free from symptoms a year afterwards.

The writer has collected twenty-six cases with rudimentary development of Müller's ducts, in which the ovaries were removed to relieve menstrual molimina. The breasts and external genitals were normal in all but two. The uterus, in the form of a muscular band, or of one or two rudimentary horns, was present in all. Both ovaries were found in nineteen, one in seven. They were found at some distance from their normal position in several cases. Thus not much value can be attached to recorded cases in which uterus and ovaries were found absent on bimanual examination.

Fifteen cases were cured by operation; in 8 nothing is said as to the effect on the menstrual molimina; 2 died from the operation; 1 was not improved, but the operator could not find either ovary.

These cases have another interest. It is customary now to leave the ovaries when performing hysterectomy for uterine disease, in order to avert the distressing symptoms of the artificial menopause. An almost parallel condition to these cases is thus created. Why in the one instance pain and other symptoms attend the condition and in the other do not the writer cannot say. But until a number of cases have been recorded of no untoward results from leaving the ovaries in cases of

hysterectomy, he will hesitate to adopt this course.

BOSTON MED. AND SURG. JOUR., Nov. 17,
p. 490.

Nasal Hydrorrhœa: Escape of Cerebro-Spinal Fluid.

Dr. A. COOLIDGE, Jun.

This case belongs to a class which has been reported as nasal hydrorrhœa—the periodic flow of a large quantity of a serous fluid from the nose, almost always unilateral, brought on sometimes by mental strain, sometimes without cause. It often occurs only when the head is bent forward. Some cases seem to be merely an excessive flow of a vasomotor rhinitis, but in many the essential features of this neurosis are absent, and vague attempts have been made to explain it as due to some local trouble of the fifth nerve, and the fluid is supposed to be the normal nasal serum. On the other hand, Tilleau describes cases in which after trauma with fracture of the cribriform plate, cerebro-spinal fluid escaped through the nose when the head was bent in a certain position.

A boy, aged 13, always in good health, had a violent "cold," which laid him up for a week. His mother thought he had lacrymation from both eyes for a few days, and a watery discharge from the right nostril. Since then the dropping of watery fluid has been constant from the right nostril when the head is bent well forward. There is none with the head erect, and no sense of dropping into the throat. He is apparently in robust health. Nothing abnormal could be found in nasal cavities or pharynx. Within twenty seconds after his head is bent forward a clear, watery fluid begins to drop from his right nostril, and continues steadily while his head is in this position at the rate of one drop per five seconds. The same is true if he lies on his face. If the fluid is allowed to flow for half an hour he complains of headache. The fluid is pale, slightly alkaline, of specific gravity, 1.010

and contains chlorine 0.046 in 10 c.c., and albumin, very slight trace. The composition is exactly that of cerebrospinal fluid. Drugs, including atropine, are useless. The dropping has been constant for five years, and he has not suffered in the least. The writer is unable to offer any explanation of this case.

ARCHIVES OF PEDIATRICS, October.

The Enanthem of Rubella.

Recently attention has been directed to the diagnostic value of the eruptions which appear on mucous membranes in the specific fevers. As the skin eruptions are termed exanthemata, so these are called enanthemata. In the *Archives of Pediatrics*, December, 1896, Dr. Hoplik, of New York, pointed out that a characteristic eruption appeared on the mucous membrane of the mouth in measles, which has been confirmed. This eruption consists of small, irregular, bright-red spots, with a minute speck in the centre, blueish-white in daylight. They are pathognomonic of measles, and are present in the pre-eruptive and eruptive stages.

Dr. F. Forcheimer claims that in rubella also a characteristic buccal enanthem appears. If his observation is confirmed, it will have a special value, for the diagnosis of this disease is difficult, and its very existence doubted by some. A throat eruption has been variously described by different writers, but never as characteristic. According to Dr. Forcheimer, the enanthem appears at the same time as the exanthem, and is evanescent, fading away in twenty-four hours. It consists of spots about the size of a large pin's head, is localised on the uvula and soft palate, and rarely extends to the hard palate. It is the same eruption as that found on the skin, characterised by its size of efflorescence, arrangement, absence of general infiltration, and, above all, by its pinky rose-red colour. During involution there are sometimes pigmented deposits, usually of a yellowish or yellowish-brown colour, in spots or streaks.

It thus differs from the enanthem of the two diseases with which rubella is confounded. In scarlatina the enanthem appears twelve to twenty-four hours before the exanthem; on the pillars of the fauces, as characteristic punctæ; it then rapidly spreads over the mouth as a scarlet red coalescing eruption. In measles the enanthem begins upon the soft palate thirty-six to forty-eight hours before the exanthem in the form of purplish or bluish papules arranged crescentically, and extends over the cheeks. It is at its maximum at the beginning of the exanthem, and may take three or four days to disappear. It is important to state that these conclusions as to rubella are based on the study of one epidemic only.

There are also certain appearances in the mouth and throat which are in no way characteristic, and which Dr. Forcheimer supposes due to secondary infection—catarrhal stomatitis, hyperæmia of the fauces, tonsillitis, and pharyngitis.

NOUVELLE ICONOGRAPHIE DE LA SALT-
PÊTRIÈRE, Sept.-Oct., p. 321.

Ankylosis of the Spine, Hips, and Shoulders: "Spondylose Rhizomelique."

By E. FEINDEL and P. FROUSSARD.

Under the name "Spondylose Rhizomelique," Dr. P. Marie, on the basis of six observations, has described an affection characterised by ankylosis of spine and roots of the limbs (hips and shoulders).

The following seventh case is described by the writers. A man, aged 27, who presented soldering of all the vertebræ, complete ankylosis of the left hip, and more or less limitation of movement in the other three joints, was seen in March, 1898. There was no family history of rheumatism. Before 1894 he had no serious illness, then he noticed pain in the right lower limb, and more rarely in the left when he walked. In 1895 these pains disappeared, but every

movement provoked sharp pain in the lumbar, sacral, and coccygeal regions. All the vertebræ, except the cervical, were ankylosed. In August, 1897, pains in the hips came on. Movements of the neck, of the

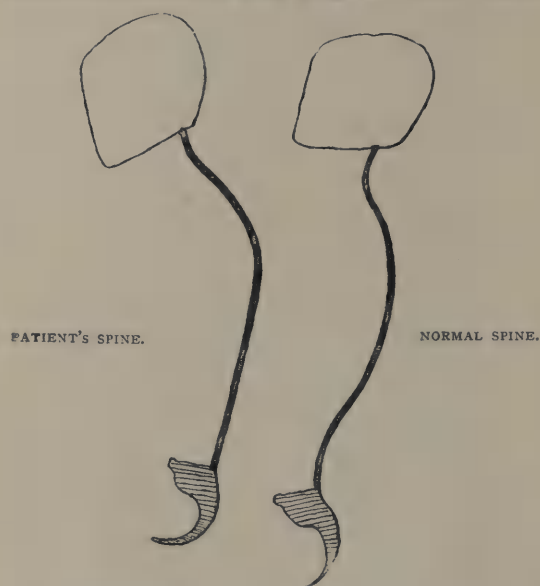
painful. There was neither fever nor swelling of joints. In August, 1898, his attitude was, as shown in the portrait, peculiar. The upper part of the body was inclined forwards, the head was slightly flexed and



right arm, and of the left thigh were painful, and accompanied by crackling. Movement of the head became almost impossible. The small joints remained sound, except the right temporo-maxillary, which became

almost immovable. The normal curvatures of the spine were altered as shown in the diagram. The thorax was flattened from before back, the ribs were almost immobile and the respiration was almost entirely

diaphragmatic. The left thigh was fixed at an angle of 150° with the pelvis; the trochanter was larger than on the right side. The movements of the right hip joint were a little diminished, and at the limit painful. There was some crackling of the knees. The right arm could not be elevated to more than an angle of 40° with the horizon. Movement of the left arm was a little limited. Movements of both were accompanied by crackling. There were nodosities of Bouchard on the middle and ring fingers of both hands.



The ætiology of this disease is very obscure. In all the cases males were affected; they were usually young. An indication of the pathology is given by observations in some cases of exostoses on the anterior surface of the vertebræ (felt in the pharynx) and on the hands, and by the thickening of the sacrum and coccyx. The skeleton of the "chat barre de fer" of Bricon (see "Spondylitis Deformans in a Cat," p. 164) and a skeleton in the Musée Dupuytren, described by Marie, also elucidate the subject. The pathological changes appear to be two-fold—production of new osseous tissue on bone (exostoses, hyperostoses, synostoses), and calcification or ossification of ligaments. The actual cause escapes observation entirely.

But the disease appears allied to myositis ossificans (see No. 1, p. 31), especially as there may be in that malady ankylosis of the spine and large joints.

As to the treatment, the writers think that daily exercise of joints still movable, movement under chloroform, if necessary, and operation may be useful.

(Diagrams in this article by kind permission of Nouvelle Iconographie de la Salpêtrière, Paris.)

LA SEMAINE MÉDICALE, Oct. 19.

Typhoid Pleurisies.

By MONS. CH. ACHARD.

The occurrence of pleurisy in typhoid fever has long been known. It may be due to localisation of the typhoid bacillus or to another infection superadded to the typhoid. Typhoid pleurisy may be sero-fibrinous, hæmorrhagic, or purulent. In some cases the pleurisy appears to have been the primary lesion of the typhoid infection and typhoid symptoms appeared only later. Similarly typhoid pneumonia may be the first manifestation of typhoid fever. But the effusion may show itself at a later period, as in the following case:—A young man, aged 26, had all the symptoms of typhoid fever. There was a little expectoration slightly mixed with blood, but no physical signs of pleuritis. At the end of a week he developed dyspnœa; the respirations were 36, and the chest was dull on the left side. Puncture gave exit to serous fluid, a little cloudy, containing red and white corpuscles. Later, a small area of broncho-pneumonia developed at the root of the right lung. Serous fluid was obtained by puncture several times during a month. The dulness then diminished and finally disappeared. The important fact is that the typhoid bacillus was obtained from the effusion in a state of purity on each occasion.

In the following case the pleurisy was not so benign:—A young woman at the end of the third week had friction at the left base. The temperature became normal and convalescence apparently was beginning, but dul-

ness appeared at both bases, and the temperature rose to 105°. Puncture at the left base gave exit to fluid exclusively sanguineous. An empyema then formed, and a litre of pus, which furnished pure cultures of the typhoid bacillus, was evacuated. Later resection and drainage became necessary. Slow recovery followed.

Why the bacilli should produce pus in some cases and not in others is unknown. But there are analogies. Osteomyelitis sometimes aborts: the painful osseous swellings resolve. In typhoid fever the spleen is constantly the seat of bacillary foci, which only exceptionally lead to abscess. Experimentally, the typhoid bacillus sometimes produces pus, sometimes does not; so, also, does the colon bacillus. Passing to habitually pyogenic microbes, streptococci and even staphylococci are sometimes found in non-suppurative lesions. Finally, in the pleural cavity the tubercle bacillus can excite any form of inflammation—fibrinous, serous, hæmorrhagic, or purulent.

A curious observation was made in the first case. The agglutinative power of the blood is usually superior to that of pathological fluids. But here the serum had a power of only 1 to 10, whilst the pleural fluid had one of 1 to 100. The fluid was also strongly bactericidal. The cultivation of the typhoid bacillus from it was difficult, and impossible when a large quantity was added to the medium.

As a rule, in typhoid empyema, operation should be delayed until the intestinal ulcers have healed and the patient has recovered strength. Complications are not so menacing as in other empyemata, notably streptococcic.

JOURNAL DE MÉDECINE ET CHIRURGIE,
October 25.

The Treatment of Fracture of the Patella by Massage.

Dr. Lucas-Championnière, who adversely criticised the treatment of the Prince of

Wales, insists on the superiority in fracture of the patella of suture and massage over all other methods, and claims a greater experience of this treatment than any other surgeon. Immobilising apparatuses are pernicious; they aggravate the secondary effects of fracture—articular and muscular. They do not cure because between the fragments there are material obstacles to fusion, but they give rise to complications which assure the impotence of the limb. Two large silver sutures should be inserted in the substance of the bone, if possible, around it if the patella is too friable or too comminuted. But under certain circumstances this serious operation may not be possible. Then let there be no hesitation. Massage and mobilisation will give most satisfactory results, or the best that can be hoped for without suture, and this even in bad conditions when personal supervision is difficult. As a proof of this Dr. Championnière publishes the account of the following case sent to him by Dr. Cardot, a military surgeon.

During military manœuvres he was called to an Alpine village where a woman, aged 49, had fractured the patella. When seen an hour and a half afterwards the joint was much swollen; the fracture was transverse; the fragments were separated the breadth of two fingers. As accessories were wanting operation was not performed. Leeches were applied, and then cold compresses. Next day the swelling was diminished and massage was performed. Dr. Cardot having to depart, instructed a domestic in this procedure, and left the patient in her hands. He saw her three times in the next month, and on each occasion found considerable progress. On the 15th day he allowed limited passive movement, on the 20th he permitted the patient to get up, and with the aid of two persons to walk round the room. Massage was practised daily for two months, and followed by hydrotherapy. Two years afterwards the patient could walk and go up and down stairs easily; there was neither stiffness of the joint nor atrophy of the quadriceps. The

fibrous callus measured no more than half a centimètre.

BERLINER KLINISCHE WOCHENSCHRIFT,
Sept. 12, 1898.

The Occurrence of Smegma-bacilli in the Sputum.

Hitherto the only bacilli likely to be confounded with the tubercle bacillus in the sputum were those of leprosy. But the clinical characters of the diseases are usually sufficient to distinguish them. It seems now, however, that the smegma-bacillus may occur in the sputum and be the cause of serious mistakes. Dr. A. Pappenheim publishes a case where a woman, aged 35, suffered from chronic diarrhoea and emaciation. After the discovery of the eggs of bothriocephalus latus and the expulsion of the worms with their heads, a good prognosis was given. However, in spite of treatment, the diarrhoea persisted. Towards the last there were symptoms of pneumonia and œdema of the lungs, and for three days before death a quantity of rods, which stained red by Gabbet's method, were found in the sputum, and were supposed to be tubercle bacilli. A diagnosis of pulmonary and intestinal tuberculosis appeared to be justifiable, but post mortem there were chronic bronchitis with bronchiectasis, and old follicular enteritis, but no trace of tubercle anywhere. The same bacilli which were present in the sputum were found in the lung. A close examination of them showed that they could not be demonstrated in sections by the methods used for tubercle bacilli; that they could not be cultivated on glycerine-agar, and that they were non-pathogenic for guinea-pigs. A characteristic difference between the smegma and the tubercle bacillus is that the former is much more easily decolourised by alcohol. After a number of experiments, Dr. Pappenheim recommends that the following method of staining tubercle bacilli should be employed in order to differentiate them from the smegma organism.

(1) Stain coverslips in boiling carbol-fuchsin.

(2) Soak up superfluous stain with blotting paper.

(3) Without washing, decolourise and counter-stain simultaneously by dipping two to five times in the following solution:—In 100 parts absolute alcohol dissolve one part of corallin (rosolic acid), and add methylene blue to saturation, then mix with twenty parts of glycerine.

(4) Wash quickly in water, dry and mount.

The smegma bacilli are first decolourised and then stained blue, while tubercle bacilli retain the fuchsin and appear red.

The author thinks that the pneumonia was caused by staphylococci, which were found both in the sputum and in sections, the smegma-bacilli being an accidental contamination, and playing no active part in its production.

BERLINER KLINISCHE WOCHENSCHRIFT.
Sept. 26, 1898.

Optic Atrophy in Locomotor Ataxy.

Prof. Silex gives statistics, based on his own large experience, bearing on the relation between optic atrophy occurring in the course of tabes and syphilis. They show, like most others, that syphilis is the most important agent in the production of tabes itself, though how and why is unknown. It is not because the antisyphilitic course has been imperfect, as Fournier believed, since locomotor ataxy may follow the most careful treatment of syphilis.

As regards the optic atrophy, its origin is obscure, and its treatment most unsatisfactory. Mercury and iodides do not benefit, and often do harm, even in post-syphilitic cases. Those which seem to be benefited by the inunction of mercury always turn out eventually to be examples, not of true tabes, but of some other disease such as glioma spinalis, or syphilis of the spinal cord (pseudo-tabes of Oppenheim). In the latter case the optic

atrophy is due to a specific basal meningitis. Prof. Silex has, therefore, tried new methods, and, under Munk's direction, has experimented with galvanism, which seemed the most rational treatment for nervous atrophy. The small currents allowable for the brain and spinal cord proved to be of no therapeutic value. Though powerless to avert optic atrophy in tabes, a sea voyage, or anything which improves the general health, may retard its development.

WIENER KLINISCHE WOCHENSCHRIFT

(No. 43, p. 974).

Bleeding after Tracheotomy.

KERMAUNER.

The causes of bleeding after the operation of tracheotomy are of considerable importance, inasmuch as not a few of the fatal cases which occur are due to this accident. In a few instances it has been suggested that the bleeding may really come from the lungs and not from the wound, but there is little evidence to support this view; at the same time it not infrequently happens that at the necropsy no source of bleeding is discovered. Bleeding in connection with the operation is divided by Foltanek (Jahrb. f. Kinderheilk, 1892, Bd. xxxiii., p. 241) into intratracheal and extratracheal varieties. The latter may occur very shortly after the operation, and be due to defective ligature of a vessel or to capillary hæmorrhage owing to raised blood pressure during a fit of coughing. This is seldom dangerous. At later stages, extratracheal hæmorrhage may take place from erosion of a vessel in the process of suppuration, from an ulcer caused by the canula, or by extension of a new growth. Kermauner quotes cases illustrating the last two accidents. The vessel wounded in the latter of these was the innominate artery, which lies in close relation to the tracheal wound in the low operation, and is probably the cause of the movement sometimes seen in the canula synchronous with the heart-beat. Injury may also

occur to the left carotid or to the arch of the aorta. Intratracheal bleeding may arise in similar ways, owing to ulceration extending through the trachea into a large vessel, or by extension of malignant growths. The writer quotes a case in which fatal bleeding from the innominate artery took place into the trachea owing to ulceration caused by the tube. In order to avoid the danger of hæmorrhage it is necessary at the close of the operation to ligature carefully every vessel, even the smallest. Soft gum elastic tubes should be used whenever possible, in order to avoid ulceration. This may occur, however, even with soft tubes, if they remain *in situ* for any length of time. Treatment in severe cases is scarcely possible, as it is often a very large vessel which is injured, and death occurs in a very few minutes by anæmia or suffocation. The writer also narrates a case in which a stomach-tube left in place for some time caused ulceration of the posterior wall of the œsophagus, which eroded a large blood vessel, and caused death. The vessel proved to be an abnormal right subclavian artery, arising from the arch of the aorta close to the left subclavian, and passing behind the œsophagus to gain its proper place.

CENTRALBLATT FÜR BAKTERIOLOGIE UND
PARASITENKUNDE, Bd. xxi. Nos. 21 to 25.

The Treatment of Malignant Tumours by Bacterial Toxins and "Anticancerous" Serum.

Dr. Roncali subjects the treatment of malignant tumours by bacteria and their products to a searching criticism.

Only fifteen cases are known where the toxins of erysipelas have permanently cured a new growth. Ten of these were cases where the occurrence of erysipelas was accidental, but their statistical value is impaired by the fact that their after history is unknown. One, a sarcoma of the neck was cured by Kleeblatt

by injections of pure cultures of the streptococcus, and four (out of a total of 160 cases) were cured by Coley, who injected the toxins of the streptococcus together with those of the *B. prodigiosus*. Against these rare successes must be placed a mass of cases where the injections have not only failed in their object, but have done harm. Pure cultures of the streptococcus have produced erysipelas, hastened metastasis, and caused degeneration of internal organs, especially of the heart. It is, therefore, remarkable that Coley, not satisfied with all these evils, should have added to those of erysipelas the toxins of the *prodigiosus*. This combination has no action antagonistic to malignant tumours. The diminution of a nodule during their use is no proof of an antagonistic action, but of a local degeneration, which might have been caused equally by Vienna paste or other caustics, which they resemble further in stimulating other parts of the tumour to renewed growth, so that it may shrink on the one hand, and on the other invade by metastasis other organs, whose powers of resistance have been lowered by the toxins. Nearly everyone who has worked with Coley's fluid has had negative results. Roncali himself, as recommended by the inventor, used extremely virulent cultures of streptococci obtained from a diphtheritic membrane and subsequently contaminated with the *prodigiosus*. His experience with this preparation was that it never cured and always had a very bad effect on the general health. One encapsuled spindle-celled fibrosarcoma, which from its nature was relatively benign, gave rise to a number of metastatic tumours, histologically more malignant, in Roncali's opinion because of, and not simply after, the injections. However this may have been, it is a common experience that secondary tumours are often less fibrous and lack the "capsule" of the parent. As regards the general health, even small injections caused a violent febrile reaction. The most striking effect, however, was rapid emaciation, and a destruction of red blood

corpuscles. The post-mortem appearances coincided with those found in chronic intoxications, and though ascribed by Roncali to the injections of toxins, could have been explained equally well as the result of an auto-intoxication from the malignant tumour.

Richet and Héricourt injected the filtered juice expressed from an osteo-sarcoma into an ass and two dogs, with the idea of injecting the serum of such "immunised" animals into patients suffering from malignant tumours. These writers claim to have had good results, but they have not been confirmed. This is not surprising since immunisation is attained by injecting strongly toxic micro-organisms or their secretory products. Now the secretory products of the blastomycetes, which, according to Sanfelice and Roncali, produce malignant tumours, are not toxic at all, and therefore the method of Richet and Héricourt is valueless.

Emmerich and Scholl use an "anti-cancerous" serum obtained from sheep, not immunised against infection by the streptococcus, but dying of a severe streptococcal infection. Their method is practically on the same principle as Fehleisen's and Coley's, since the serum is extremely rich in the toxins of the streptococcus *erysipelatosus*, the only difference between them being that while with Coley's method the organisms secrete their toxins in broth, with that of Emmerich and Scholl they do so in the blood of a living animal. In all probability, therefore, this serum is more toxic and dangerous than Coley's fluid.

The writer brings forward other theoretical reasons why serum thus prepared can never succeed. It seems to us, however, that now Coley's fluid has entered the field of practical surgery, the question of its value must be settled there. In short, Roncali's criticism, however justifiable theoretically, is premature. The few positive cases of recovery have not been watched long enough to be sure that the cure is permanent, but in a condition so hopeless as malignant disease they indicate the

necessity of a further trial of the method, at any rate in cases which are not amenable to operation.

CENTRALBLATT FÜR INNERE MEDICIN,
Nov. 26, 1898.

The Action of Bile-acids on the Central Nervous System.

Drs. Biedl and Kraus publish experiments which throw considerable light on the pathogenesis of the grave nervous disturbances sometimes met with in jaundice. That bile-acids were poisonous when brought into direct contact with living tissues, such as muscle and nerve, and that they break up the red blood corpuscles has long been known. Though, when injected subcutaneously or intravenously, they produce some of the symptoms of jaundice, such as a slow pulse, a fall of blood pressure, and depression of the central nervous system, the clinical symptoms of icterus gravis (violent excitement, delirium, and convulsions) have never been reproduced experimentally.

The writers found that in rabbits, when a few drops of bile are injected under the dura mater through a trephine hole, the animal begins to run about wildly, exactly as though that part of the nucleus caudatus called by Nothnagel the "nodus cursorius," had been stimulated. With a fairly large dose of bile this first stage is generally succeeded by a second, with clonic spasms beginning in the maxillary muscles, and going on to opisthotonos, clonic spasms of the limbs, and nystagmus. The salivary secretion is greatly increased. Death generally ensues. With unimportant differences, the same effects were observed in mice, guinea-pigs, and dogs. The symptoms were specific and not caused by the method since (1) they are not the symptoms of cerebral pressure, (2) they are not produced by injecting other substances such as water or normal urine, and (3) a direct injury to the nodus cursorius was impossible. Further experiments showed that the con-

stituents of the bile concerned were the bile acids, which produced the same effects as the bile itself. Subdural injections of icteric urine (0.5 to 1 c.c.) have the same effect as bile acids.

Other methods, which did not bring the bile acids into direct contact with the brain substance, such as injecting them into the carotid towards the brain, failed to produce these effects. A possible explanation is that either the bile acids undergo some change in the blood-stream, or more likely that they are unable to pass through the relatively impermeable walls of the cerebral vessels. Such an elective action is analogous to that of morphine, which is poisonous for rabbits only when injected into the cerebral substance, and to that of suprarenal extract, which is a vaso-constrictor only when injected intravenously. And, indeed, the brain-matter seems to have a peculiar affinity for bile-acids, since when these are introduced subdurally, they do not cause slowing of the pulse, fall of blood pressure, or hæmoglobinuria, which proves that they do not pass out of the brain into the circulation.

THERAPEUTISCHE BEILAGE DER DEUTSCHEN MED. WOCHENSCHRIFT, Oct. 6, 1898.

Silver in Surgical Practice.

Dr. Oscar Werler reports three cases illustrating the excellent results obtained by Credé's method of inunction of soluble metallic silver in the treatment of septic wounds and septicæmia, whether acute or chronic. He states that there is no doubt that as *argentum colloidal* in a 15 per cent. ointment (Credé's ointment) it is rapidly absorbed into the blood and there acts as a general disinfectant, which is able to destroy any bacteria or toxins it may meet with. The first was a case of rapidly spreading acute septic cellulitis of the hand in a girl aged 9. Her general condition pointed to commencing septicæmia and her pulse was 120. After one inunction of 15 grains of

the ointment on the skin of the healthy side of the body all the alarming general symptoms subsided, and the local cellulitis ceased to spread. Complete cure followed the fourth inunction. At the same time compresses of itrol (silver citrate) were used locally. The second case was that of a woman, aged 38, with phlegmonous erysipelas over both external malleoli grafted on an old fissured eczema of the heels, which had resisted all treatment for four years. There were also signs of septic absorption as shown by fever, headache, insomnia, lassitude, and anorexia. Credé's ointment was rubbed in every other day over healthy skin, and all symptoms, local and general, disappeared. The third was a case of chronic furunculosis in a woman aged 53, in whom a chronic septic infection was also diagnosed. No fresh furuncles appeared after the third inunction, and cure was complete after the tenth. In chronic cases, however, as many as twenty inunctions may be necessary. In all three cases, and this is the rule, the treatment first influenced the general condition of the patient, which improved a few hours after the first inunction.

The writer claims that soluble metallic silver, especially in the form of Credé's ointment, is a genuine specific against acute and chronic wound infection, provided the cases are diagnosed early, and before grave secondary complications have developed.

WIENER KLINISCHE RUNDSCHAU.

(Nos. 36 and 37.)

Degenerative Products: Mucoïd, Colloid, and Hyaline Changes.

In the September numbers Professor Babes discusses the subject of degeneration-products in the cells of the animal tissues, and deals with mucoïd, colloid, and hyaline changes occurring in consequence of morbid metabolism. He considers that all of the generally recognised degenerative products are closely allied, and that amyloid substance is only a variation of hyaline degeneration. Professor

Babes makes an interesting point of the apparent influence of one degenerative product upon the formation of another in the case of the secretory product of the thyroid gland—a colloid material—the absence of which seems to determine the formation of a large quantity of mucoïd matter in the tissues. But it is not by any means certain that the colloid material secreted by the thyroid is the active principle, while it has been denied that mucin bears any part in the peculiar change that takes place in the connective tissues.

Professor Babes traces almost all forms of degeneration to the action of poisons upon the tissues, and by far the most frequent sources of such poisons are the various pathogenic bacteria. Thus, to take some of the examples which he gives, the toxins of the typhoid bacillus give rise to the peculiar degeneration of the muscles, known as Zenker's degeneration, which is a form of hyaline change. It should, perhaps, be called a "coagulation necrosis." Bacteria again are responsible for the mucous degeneration undergone by cells of mucous membranes in catarrhal diseases, of which bronchitis is a type. The cultures of certain bacteria have the effect of converting nutrient media into a slimy mass analogous to mucin, and the products of these organisms can be isolated and shown to produce a similar effect. In hæmorrhagic conditions, such as occur in malignant forms of acute diseases, the vessel walls undergo a hyaline change, owing to the action of toxines existing in the circulation, and the brittleness of the vascular walls thus produced permits the escape of the blood. A similar condition is stated to occur in hereditary "bleeders."

That other toxines besides those of infective microbes can cause degeneration of tissue-cells is shown by the degeneration of nerve cells, which occurs in peripheral neuritis, due to alcohol, lead, or other such agents. This degeneration is considered a variety of hyaline degeneration. It may also occur, as

is well known, after infectious diseases. The action of phosphorus in causing fatty degeneration—a form not dealt with in the article now under review—is a similar instance.

The frequency of degeneration of all kinds in the cells of tumours is noticed, but not discussed. It may be of interest to note that the hyaline masses found in the cells of malignant tumours appear to constitute one of the bodies which have been claimed as blastomycetes by various observers.

MÜNCHENER MEDICINISCHE WOCHENSCHRIFT, Sept. 27, 1898.

Oberst's Regional Anæsthesia.

Dr. Gerhardt strongly recommends a method of local anæsthesia, which was introduced by Oberst of Halle ten years ago, and therefore before Schleich's infiltration method.

In, for instance, the case of the finger or toe, it is applied as follows: a ligature is first placed tightly round the member on the proximal side of the lesion. Immediately on the peripheral side of this ligature, but still in healthy tissue, the four digital nerves are paralysed by injecting at each of the four "corners" of the finger $\frac{1}{4}$ to $\frac{1}{3}$ or even $\frac{1}{2}$ gramme of a freshly-prepared 1 per cent. cocaine solution. Complete anæsthesia follows in four or five minutes. The ligature serves the double purpose of rendering the operation bloodless, and preventing the cocaine being carried away into the blood stream. On this account the amount of cocaine required is inconsiderable, at the most $\frac{3}{10}$ of a grain, and this quantity is quite independent of the magnitude of the subsequent operation, which is not the case in Schleich's method. The procedure is specially suitable for small, though painful, operations on the fingers and toes, for whitlows, caries, ingrowing toe-nails, &c., though favourable results have been reported of late even in major operations on the limbs. Schleich's

method is much less satisfactory, as the injections are made into the inflamed tissues, and are at first extremely painful, while in Oberst's method the punctures are made into healthy tissue, and can be rendered quite painless by a short application of the ethyl chloride spray.

A New Serum for the Treatment of Diphtheria.

Dr. Weisbecker has treated 30 children, suffering from diphtheria, with the serum obtained, not from an immunised animal, but from convalescent patients. All of them could be looked upon as potentially severe cases from the character of the then prevailing epidemic. The death-rate with the new serum, but also including cases which received no injections, was 12 to 13 per cent. In some respects this serum resembles Behring's—for instance, the earlier it is injected the greater its effect, but it differs in the following:—(1) It at first usually causes a rapid improvement in the general condition, the intense prostration giving place to a feeling of well-being, and the headache and pains in the neck vanishing in a few minutes. Even if there is no subjective improvement, it is soon possible, except in the worst cases, to see that the infection threatens no further danger to the organism, the facial expression being the chief guide. (2) Often the serum seems to have no effect on the temperature or on the local process. The former may continue to rise and the latter to spread after an injection. This, however, does not warrant a worse prognosis, which must be made from the general condition of the patient alone. (3) When laryngitis is present the above rule does not apply. In fact, the serum seems to have a specially favourable influence on the laryngitis. If an early injection is made it does not advance to stenosis, and the croupy cough soon becomes catarrhal. Even when stenosis is established and tracheotomy is required an injection may do good. A rise of temperature following the injection,

generally accompanied by profuse sweating, is of good omen in these cases. (4) Profuse sweating and great and rapid variations of temperature were often observed, but does not appear to have been unfavourable. (5) Only one injection is necessary, and a continuance of the fever and spread of the membrane is no indication for a second. If the first fail repetitions are useless. The only exception is in the case of a relapse. The dose is 4 to 6 c.c. for young children, 8 to 10 c.c. for older. (6) Sequelæ are said to be less common than after the use of ordinary antitoxin.

As regards the serum itself.—(1) The individual convalescents from whom the serum is to be obtained must be chosen according to certain rules, which, however, the author does not formulate at present. (2) The patient must have recovered spontaneously, that is, without the aid of injections, whether of Weisbecker's or of Behring's serum.

These results are interesting, but the number of cases recorded is too small to base any definite conclusions upon. The method, however, would seem to deserve further trial.

GIORNALE ITAL. DELLE MAL. VEN. E
DELLA PELLE. 1898 FASC. iii., p. 205.

Demodex Folliculorum Causing Discolouration of the Skin.

DE AMICIS.

Professor De Amicis relates a case in which a brownish discolouration appeared on the face of a young woman, involving the chin and upper lip. The colour suggested at first some vegetable parasite, such as the *microsporon furfur* (tinea versicolor), but microscopic examination did not show the spores of any fungus, revealing instead a very large number of specimens of the *demodex folliculorum*. Treatment with soap and antiseptics caused the disappearance both of the parasite and of the discolouration. The demodex has hitherto been regarded as a

harmless guest in the follicles of the human skin, though capable of causing a species of mange in dogs, but this case suggests that it may be less innocent than has been supposed. In the discussion at the Italian Dermatological Society, following the paper of De Amicis, Professor Majocchi narrated two cases that had come under his own observation, in which a similar pigmentation had been found associated with this parasite.

MEDICAL SOCIETIES.

ROYAL MED. AND CHIRURG. SOC., Nov. 8.

Congenital Hypertrophic Stenosis of the Pylorus.

Dr. Edmund Cautley said that the condition was one in which the pylorus was found, post mortem, represented by a well-defined, cylindrical, thick-walled tube, with its lumen exceedingly small or completely occluded. The affection was of importance in its immediate effect on the life of the infant, and probably also in its relationship, when present in a modified form, to the hypertrophic stenosis of the pylorus in adults.

Twenty cases had been recorded. A male infant died in the fifteenth week of life from vomiting and marasmus. Constipation was present from birth and vomiting began at the age of three weeks and persisted. Another abnormality was present—viz., a large cavity in the right hemisphere of the brain. The second case was that of a male infant who died in the eighth week of life "in a fit." Vomiting had commenced a few days after birth, and the child rapidly wasted.

The following were regarded as characteristic features of the disease: (1) vomiting, occurring without apparent cause and persisting in spite of treatment; (2) the absence of bile from the vomited matter; (3) obstinate constipation; (4) marasmus; (5) the presence of a tumour in the region of the pylorus; (6) the

absence of abdominal distension except from dilatation of the stomach itself in some instances; and (7) the absence of signs or symptoms of gastritis and of the more common forms of intestinal obstruction. The child was usually "a fine baby born." Symptoms might occur within a few days of birth or later in life, but almost invariably within the first month. The pylorus was about an inch long, forming a firm, thick, elongated tumour, well defined at either end, and about the size of the last joint of the little finger. The thickening was due to a relatively immense hypertrophy of the unstriped circular muscle-fibres forming the middle coat of the pylorus. The other changes which might be present were secondary to the stenosis produced by the contraction of this hypertrophied muscle. Thus the mucous membrane was thrown into longitudinal folds. The stomach and œsophagus might be dilated, and the former might present signs of secondary gastric catarrh. Diagnosis depended on the characteristic symptoms arising during the first few weeks of life and the presence of a tumour. The tumour had been noted in two cases during life. Treatment must be merely palliative unless the presence of the tumour could be demonstrated. In such a case Dr. Cautley suggested surgical measures. No explanation was given of the causation, but it was suggested that there might be redundancy of foetal growth, due to the effort of nature to provide an efficient pyloric sphincter.

epidemics of diarrhœa were an improved condition of milk supply—a greater care of the health and cleanliness of the cows and byres, a rapid cooling of the milk to a temperature of 40°F., and maintenance of this temperature during the conveyance of the milk to the consumer.

The first indication for treatment is the evacuation of the contents of the stomach and alimentary canal. The vomiting which usually occurs is doubtless salutary, and may be assisted by means of warm water if the child will take it; or, better still, the stomach may be washed out. Stomach washing is urgently called for in cases with no vomiting and much collapse. Calomel is the best evacuant drug; if there is no vomiting it should be given in $\frac{1}{2}$ gr. or 1 gr. doses and repeated once. If the vomiting is troublesome, doses of from $\frac{1}{8}$ gr. to $\frac{1}{10}$ gr. should be given half-hourly. All milk must be stopped, and barley water, white of egg in sugar water, and chicken tea or whey given in small quantities at a time. Diluted brandy, if there is any appearance of heart failure, should be given. Very many drugs have been used, and recently drugs which are supposed to disinfect the alimentary canal have been much in vogue; but they are disappointing. Bismuth nitrate in large doses, from 5 to 15 gr. every two or three hours, is as useful as any. Opium has fallen to some extent into disrepute in the treatment of infantile diarrhœa, and, Dr. Ashby believes undeservedly so. The griping and colic caused by the enteritis can certainly be soothed by small doses of opiates and the excessive drain on the system checked. Enemas of starch and opium or $\frac{1}{2}$ gr. of Dover's powder repeated every hour or two may be safely given within forty-eight hours of the onset of the attack to infants six months or a year old, provided there is no marked drowsiness or contraction of the pupils. Washing out the large bowel by enemas of starch and boric acid by means of a soft indiarubber catheter attached to a ball

CLINICAL SOCIETY OF MANCHESTER.

October 18.

The Treatment of Summer Diarrhœa in Children.

Dr. Ashby said that the heat wave supplied conditions for increased growth and virulence of organisms liable to contaminate cows' milk, which, in the alimentary canal, formed toxins, and gave rise to enteritis. Among the most important means for preventing

syringe or funnel is certainly useful; from 20 to 30 oz. may be injected and allowed to escape by the side of the catheter. In this way the fæcal matter and toxins may be removed, and the irritable bowel soothed.

CLINICAL SOCIETY OF LONDON,
Nov. 11.

Restoration of the Shaft of the Ulna by Insertion of a Rabbit's Femur.

Mr. Arbuthnot Lane showed two cases illustrating the restoration of the shaft of the ulna by the insertion of the femur of a rabbit. One of the patients was a child the subject of a congenital abnormality of the shaft of the ulna. She had suffered from a progressive incapacity and deformity of the forearm and hand since birth. It hung in a position of considerable flexion and abduction when the child attempted to use it, which she did very imperfectly. The ulna consisted of two separate parts, the pointed extremities of which overlapped and the axes of which varied considerably in direction. The lower end of the ulna was situated considerably above that of the radius. He exposed both fragments freely and separated them from the surrounding parts. Extension was made on the lower fragment till the hand assumed its normal position. The femur of a rabbit was split longitudinally and its halves were wired securely to the fragments so as to bring their longitudinal axes into their normal relationship to one another and to retain the lower fragment on a level with the lower end of the radius. The result of this operation was most satisfactory both as regarded the removal of the deformity and the restoration of the normal functions to the part. The second was that of a man, aged nineteen years, who lost the shaft of the ulna in 1896. He was admitted into Guy's Hospital in September, 1898, when the radiograph showed that there extended from either extremity of the ulna a fine spicule of bone. An incision was made along the length of the ulna and these spicules were exposed and freed from the soft parts in

which they were embedded. A femur of a very large rabbit was then wired securely to the ends of the ulna, the spicules being included in the loops of wire. The result as shown by the skiagraph was most satisfactory, and Mr. Lane hoped at a later date to render the usefulness of the arm even more complete by removing some of the new bone which had been thrown out about the extremities of the ulna in consequence of the original inflammation.

EDINBURGH MEDICO-CHIRURGICAL SOC.,
Nov. 2.

Tuberculous Neuritis.

Dr. Alexander James said that any part of the nervous system might be affected—cranial nerves, phrenics, &c. The condition was remarkable for its tendency to appear, disappear, and again reappear. It was therefore mistaken for hysteria. He narrated several cases. The first case was that of a phthisical man, aged 40. The skin sensibility over the legs and feet was slightly impaired; formication had been present and there was a degree of tenderness in the muscles. Evidences of neuritis became more marked in both legs, as shown by drop-foot, loss of power of extension, and pain in the muscles. The reflexes were absent and electrical reactions diminished. In this case the motor paralysis was greater than the sensory. The second case showed that sensory tracts may be more affected than the motor. A boy, aged 16, suffered from lupus, tarsal tuberculosis, and advanced phthisis. He lost feeling in the right arm and leg, and, to a lesser extent, in the right side of the face. There were no motor affections. This condition lasted three days, but had entirely disappeared in a week. A month later, however, the right arm and leg were numb, and to a less extent the right side of the face and trunk. Sensibility to heat and touch were also lessened. He complained of pain on the right side of the head when it was combed. The muscles of the affected arm and leg were tender and wasted.

The knee-jerks were increased, especially on the right side. The third case was that of a phthisical man, aged 22; the motor nerves were chiefly affected, but the duration was short. He complained of loss of power in the left arm during four months, with stiffness of the wrist. The left arm was smaller than the right, the muscles being considerably atrophied and paralysed. The sensibility to touch, pain, and temperature was hardly affected, but the muscles were painful. Electrical and reflex excitability were increased. The left knee-jerk was more marked than the right, and ankle clonus was present in the left leg. The left wrist was affected by tuberculous disease. Under treatment the motor power increased remarkably.

SOCIÉTÉ MÉD. DES HÔPITAUX, April 22.

Auto-Inoculation of Tuberculosis During Phthisis.

Tuberculosis of the skin is with the rarest exceptions never secondary to tuberculosis of other parts; indeed, many of the subjects of lupus vulgaris enjoy excellent health. Why the manifestations of tuberculosis should in some cases be confined to the skin, in others to the lymphatic glands, in others to the lungs or other organs, and in others more or less generalised, is not known. In spite of all the knowledge which has resulted from the discovery of the bacillus tuberculosis, pathology, as in many diseases, fails to account for all the clinical facts. The predisposition, which must be assumed to explain the occurrence of tuberculosis in certain persons, may evidently be a property not, as is generally supposed, of the individual as a whole, but of a single tissue. At this meeting of the Société Médicale des Hôpitaux, Dr. M. A. Bécclère brought forward a most interesting series of cases which at first sight seems an exception to the generalisations advanced. At the Tenon hospital he had observed within a year no less than four cases in which the subjects of phthisis developed verrucose tuberculosis on the back of the hand; in

three the lesion occupied the back of the thumb exactly at the metacarpophalangeal joint; in the fourth—the back of the first phalanx of the index finger. In two cases the disease followed an accidental wound. One of the patients was a mason who frequently wiped his upper lip with the back of his right hand during his work, to remove the dust from his moustache. Another had an inveterate habit of rubbing strongly the upper lip to relieve itching. These cases therefore bore out the explanation put forward in 1889 by Vidal of this verrucose tuberculosis located on the dorsum of the thumb—that a portion of expectoration became fixed to the moustache and lips, and was transferred to the back of the thumb in rubbing the lips. The frequency of the lesion in men and its rarity in women bears out this explanation. As far as we know, though familiar to the French writers, this complication of phthisis has not been observed in this country. But the same lesion produced by inoculation of the fingers of those in the habit of making necropsies (*verruca necrogenica*) is, of course, well known.

MEDICAL SOCIETY OF BERLIN, Oct. 19.

Removal of the Only Secreting Kidney.

DR. LITTEN.

A woman passed daily $1\frac{1}{2}$ to 2 litres of urine containing pus. In the right hypochondrium was a fluctuating tumour. The cystoscope showed that the pus came from the right ureter; the orifice of the left could not be seen. Supposing the left kidney to be sound, right nephrectomy was performed. Anuria and death followed. The necropsy showed that the left kidney was more degenerated than the right, that the ureter was obliterated, and that its vesical orifice was difficult to find. The disease in both kidneys was of calculous origin. The case shows the necessity of ascertaining the condition of the other kidney before performing nephrectomy.

EPITOME OF CURRENT LITERATURE.

MEDICINE.

The Etiology and Prophylaxis of Tuberculosis.—Andvord (*Norsk. Mag. for Lægevid.*, 1898, No. 4) bases his paper partly on the extraordinary constancy of the death-rate from tuberculosis at all ages in any particular locality, and partly on the after-history of 814 children who had been treated in hospital for "scrophulo-tuberculosis." It was found that 60 per cent. of these were in excellent health, while a third had either succumbed to tuberculosis or were suffering from it at the time the enquiry was made. This shows that the percentage of persons with tuberculous phthisis rises with increasing age. The writer, therefore, comes to the conclusion that infection with the tubercle bacilli begins, as a rule, in childhood, and that in crowded areas the whole population is more or less infected, and inherits the predisposition to infection. The tuberculosis death-rate in any locality depends on a local constant, which Andvord considers to be the inherited or acquired power of resistance of its inhabitants to the infection. The practical conclusion is, that, in the battle against tuberculosis, the chief point is to protect the children from infection, and therefore to attack all enlarged tuberculous glands.

Meningeal Hæmorrhage in the Course of Purpura.—Havas (*Deutsche Med. Wochenschrift*, Sept. 8, 1898) reports a case of this complication in a girl aged 3 years. There was a history of hæmophilia in the father's family. The child was convalescent from measles when purpura hæmorrhagica set in, with bleeding from the nose, mouth, and intestine. After this had continued for a fortnight clonic spasms on the left side of the mouth, and later in the left arm, were observed. These were followed by left glosso-facial monoplegia, and paresis of the left arm, with recurrent epileptiform convulsions in the paralysed parts. There were headache and vomiting, a contracted condition of the left leg, and finally coma and high ante-mortem temperature. A diagnosis of either a hæmatoma of the dura mater

or a considerable hæmorrhage over the pia mater was made. The site of the hæmorrhage was, on the first day, over the lowest part of the right anterior central convolution (paralysis of facial and of hypoglossal), but extended on the second over the middle third of the right central convolution. The contraction of the left leg was probably due to irritation of the neighbouring leg centre (paracentral lobule).

Malt Soup as a Food for Infants with Gastro-enteric Disorders.—Keller (*Deutsche Med. Wochenschrift*, Sept. 29, 1898), in the belief that none of the newer preparations of "humanised" cows' milk, including Gaertner's "fat-milk," are able to replace mothers' milk successfully, or have had any effect in reducing infant mortality, has carefully investigated the physiology and pathology of infant metabolism. His results show that, in infants with gastro-enteric disorders, the food must be strongly alkaline; much casein and fat must be avoided, and to some extent replaced by easily oxidisable carbohydrates. He strongly recommends the following receipt both on practical and theoretical grounds. 50 grammes of wheaten flour are stirred up thoroughly in one-third of a litre of cows' milk and strained. In another vessel 100 grammes of extract of malt are dissolved in two-thirds of a litre of water at 50° C., and 10 c.c. of an 11 per cent. solution of bicarbonate of potassium added. The two are mixed together and boiled. It is then ready for use. This preparation has been extensively used both for out- and in-patient infants with gastro-enteric disorders at the Breslau Hospital, and all the physicians there are convinced of its superiority over all other artificial combinations. The babies gain weight during its administration, and no bad cases of rickets have occurred.

The Part Played by Bacteria in Infantile Gastro-Enteric Disorders.—Escherich (*Deutsche Med. Wochenschrift*, Nos. 40 and 41), states that our knowledge of abnormal fermentations in the gastro-enteric tract of infants has hardly advanced in the last ten years. Bacterioscopic examination of the discharges, especially if stained by Weigert's fibrine method and counter-stained with fuchsin, shows that the appearances in diseased conditions differ from the normal.

The bacteria normally present in the intestines of infants are probably not merely the sum of those swallowed in the food, but the healthy intestine has a constant and specific bacterial flora, which decomposes carbohydrates in a certain manner. When this process is upset by an invasion of foreign organisms, disease follows, but if the child recovers, the microscope shows that as the cure advances the appearance of the stools gradually returns to the normal. Gastro-enteric disorders can be divided into, (1) those where the decomposition occurs outside the body in the food, and (2) those where it occurs inside (endogenous). The former can be only partly avoided by boiling the milk, which may still contain acids and abnormal bye-products of fermentation. If the number and kind of the living bacteria present in the milk when swallowed were really so important as is often supposed, the difference in the mortality between breast and bottle-fed babies should be much greater even than it is, and the results of sterilising cow's milk much more brilliant than they are. As a fact, sterile milk never reaches the intestines as such: it has to pass two places where bacteria are present—viz., the mouth and the stomach. Any delay in these places, especially in the mouth, as when vomited pieces of curd are allowed to remain in it, is a special source of danger. The bacteria which usually set up abnormal fermentation are those producing acids at the expense of carbohydrate food, though, as researches with the serum reaction have shown, the bacillus coli may be the cause of one variety of infectious colitis. Putrid decomposition of proteids is rarer, and is only possible in an infant's intestines when no carbohydrates are present. This is especially likely to be the case after violent vomiting and diarrhoea, when a quantity of intestinal secretion, which is specially prone to decompose, is poured out. Endogenous infection usually attacks children, breast-fed as well as bottle, but more often the latter, who have had signs of dyspepsia and malnutrition for some time, and who fall an easy prey to the accidental introduction of some abnormal ferment. There is no doubt from the clinical symptoms and epidemic extension of infant intestinal disorders, that a large and probably the most dangerous part of them are infectious diseases. This class is chiefly due to infection with

a streptococcus, biologically very closely allied to the pneumococcus, the clinical symptoms being a serous catarrh with high fever and often convulsions: in the worst cases the process is localised in the large intestine, and the cocci produce septicæmia by penetrating into the blood and urine.

The Valuelessness of Drugs in the Treatment of Gout.—Dr. Arthur P. Luff (*Lancet*, 1898, No. 3902, p. 1606) states that the treatment of this disease by alkalies is mainly based on the assumption that uric acid is present as such in the blood and tissues, and is rendered soluble by the administration of alkalies, that uratic deposits of sodium biurate are dissolved by alkalies, and that the system of a gouty person is pervaded by a general acidity which is neutralised and removed by alkalies. With regard to the first assumption, it is now well known that in gouty subjects uric acid is never present as such in the blood and tissues, but is always combined with sodium as the quadriurate or biurate. The only way in which alkalies could beneficially affect the quadriurate would be to delay its conversion into the biurate. Experiments with an artificial blood-serum to which potassium carbonate, potassium citrate, lithium carbonate, lithium citrate, sodium bicarbonate, sodium phosphate, piperazine and lysidin were added in solution showed that this conversion is not delayed. The following do not in the slightest degree increase the solvent power of the blood for gouty deposits: Potassium carbonate, potassium citrate, lithium carbonate, lithium citrate, sodium phosphate, piperazine and lysidin. Sodium bicarbonate slightly decreases the solvent power of the blood for gouty deposits. The assumption that in connection with gout there is a general acidity of the system which causes a diminished alkalinity in the blood is opposed to the results of recent investigations upon the subject. Klemperer showed that the alkalinity in the blood in gout is very little, if at all, diminished, and that corresponding variations in the alkalinity of the blood may frequently be met with in healthy individuals. Moreover, a diminution of the alkalinity of blood serum containing uric acid in solution does not facilitate the deposition of sodium biurate from it, nor does

a diminution in the alkalinity of blood-serum diminish its solvent power. Experiments with sodium salicylate show that it has no direct action either in delaying the decomposition of sodium quadriurate, or in effecting a solvent action on deposits of sodium biurate. The supposed solvent effect of sodium salicylate for gouty deposits does not, therefore, exist. The correct explanation of the increased elimination of uric acid in the urine during the administration of sodium salicylate is that salicylic acid unites readily with glycocine, and so conveys an increased amount of that body to the kidneys, where, by its combination with urea, an increased amount of uric acid is necessarily formed. This increased formation of uric acid is directly detrimental to gouty subjects, and on that account the salicylates are contraindicated in that disease. The general conclusions are that the ordinary alkalies, lithium salts, piperazine, and lysidin are useless, and sodium salicylate is also apparently contraindicated in gout.—*Amer. Jour. of Med. Sciences.*

General Paralysis and the Tetanus Bacillus.

—Montesano and Montessori (*Centralbl. f. Bakter. u. Parasitenkunde*, Bd. xxii., No. 22 u. 23) made pure cultures of the tetanus bacillus and the streptococcus pyogenes from the cerebro-spinal fluid taken from a case of general paralysis of the insane by lumbar puncture. The inoculation of animals with these bacilli produced tetanus, though the patient during life had shown no symptom of this disease. The writers believe, that general paralysis is an infective disease, and, in spite of a negative search for the bacteria in ten other cases, that the tetanus bacilli had a causal relation to the paralysis, or at least to the epileptic fits which occurred in its course. Both this patient himself and his father had had syphilis.

Chronic Tonsillar Abscesses and their Results.

—(*Berliner Verein für innere Medizin*, Oct. 24, 1898.) Dr. Treitel observed that it is now well known that acute infective processes may result from tonsillar affections, and that there is a relation between sore throat and articular rheumatism, pleurisy, perityphlitis, and pyæmia. A series of cases of septicæmia starting from the tonsils has been published, in many of which the primary focus

was so slight as to be unnoticeable. It is probable that even the streptococci, which are normally present in the lacunæ may, under certain unknown conditions, become virulent and give rise to septic infection. Especially grave conditions may arise if the abscesses are situated deeply in the tonsils. Such a case Dr. Treitel observed himself. A man, aged 63, became ill with slight huskiness and fever, and difficulty in swallowing. A laryngoscopic examination revealed an œdematous swelling of the epiglottis and aryepiglottic folds. The dyspnœa increased and tracheotomy was performed, when a foul-smelling abscess over the tracheal cartilages was opened. The man died. Post-mortem, there was found recent mediastinal suppuration and multiple tonsillar abscesses, which, from their thickened walls, were evidently old.

Such chronic abscesses are not infrequently the starting point of a wide-spreading infection, though it is the exception to be able to diagnose them during life. It is, therefore, good practice to lay open tonsillar lacunæ in patients who are subject to frequent sore throats, and to insist on cleanliness of the mouth and nose.

Dr. Benda pointed out that a distinction between infective diseases which may invade the system through the tonsils, and true pyæmias arising from tonsillar abscesses.

The Dosage of Belladonna and Nux Vomica.

—Dr. Leech (*Brit. Med. Jour.*, Nov. 12, p. 1495). The investigations of pharmacists subsequent to the publication of the 1885 *Pharmacopœia*, show that accurate dosage with the official preparations of belladonna and nux vomica is impossible, since, however carefully such preparations are made, their strength may widely vary owing to the difference in the amount of alkaloid contained in the crude drugs themselves; hence the necessity for the changes made in the *Pharmacopœia* of 1898. The alkaloid contained in the maximum doses of the preparations of belladonna in the 1885 *B.P.* varies from $\frac{1}{900}$ to $\frac{1}{75}$ of a grain. In standardised preparation of the 1898 *B.P.* the width of limit has been greatly lessened. The largest dose of the new tincture (15 M) corresponds to $\frac{1}{150}$ grain of alkaloid; the largest dose of the alcoholic extract to $\frac{1}{100}$ grain, these amounts being equivalent to about two-thirds and 1 drop of

liquor atropinæ sulphatis respectively. The tincture and extract of nux vomica have been rendered likewise much less variable in strength than formerly by standardising according to the amount of strychnine instead of according to the amount of total alkaloid contained.

Weil's Disease.—L. Klein and F. Schütz (*Wiener Med. Wochenschrift*, No. 6-8, 1898) have observed six cases of Weil's disease, in all of which the cardinal symptoms—viz., fever, nephritis, and jaundice—were present. The disease is ushered in by fever, which begins suddenly, quickly attains a maximum, and falls to normal in five to six days by lysis. At the same time there are violent muscular pains, and pains in the neck, with sore throat. The urine is always albuminous, and often contains casts. The pulse rate is generally quickened, but may be subnormal. Jaundice appears simultaneously with the fall of temperature; and, therefore, five to six days after the onset. About this time the liver is almost always enlarged. The spleen is generally enlarged from the beginning. Grave cerebral symptoms and vomiting often appear with the jaundice, so that they have some relation to those accompanying icterus gravis. There is no rule as to the state of the bowels. Cutaneous petechiæ are common.

The disease always begins very acutely, but improvement is noticeable in a few days, and convalescence, though eventually tedious, is established in the second week.

All the writer's patients had been bathing in dirty water, which had been sometimes swallowed. The outbreak of the disease, which occurred in barracks, ceased immediately on forbidding bathing. One patient had, also, been eating bad meat, which is supposed to be a frequent cause of the disease. The poison gains admission from the digestive tract, and possibly, in some cases, through the throat.

Chronic Jaundice with Enlargement of the Spleen.—J. Levy (*Thèse de Paris*, 1898) calls attention to variety a of chronic jaundice whose clinical characters are, (1) chronic icterus of uncertain duration, appearing paroxysmally, with moderate enlargement of the liver during the attacks, (2) considerable hypertrophy (permanent) of the spleen, which during the paroxysm is

congested, and which becomes more and more sclerosed, (3) digestive disturbances, (4) mostly intense anæmia, but (5) no ascites or collateral venous circulation. The cause seems to be an ascending infection of gastro-intestinal origin, which reaches the larger bile-ducts. Unless this jaundice is distinguished from that due to gall-stones, it may lead to unnecessary surgical operations. The prognosis is favourable as the disease may last for twenty years or more. This variety may be classified among the simple chronic infective jaundices. Hayem has proposed the name, "Ictère infectieux chronique splénomégalyque à poussées paroxystiques."

Pneumonia with Empyema, Cerebral Abscess and Meningitis.—Aufrecht (*Deutsches Archiv. für Klin. Med.*, Bd. lix. Hft. 5 u. 6) reports a case where a pleural effusion was diagnosed during a typical attack of pneumonia, with rusty sputum and pain in the left lumbar region. A week after the onset of the pneumonia the patient had severe cerebral symptoms, which lasted for twenty-four hours only. Eight days later an operation for empyema was performed, and this was followed by a slow recovery. Eight days after the discharge from hospital he was seized with fever, vomiting, and retraction of the head, which were followed by coma and rapid death. Post-mortem recent purulent meningitis was found, which had started from an abscess in the left corpus striatum. The writer thinks there can be no doubt that this abscess was metastatic, had begun during the pneumonia, and, after lying latent for two months had ruptured into the lateral ventricle.

Locomotor Ataxy and Syphilis.—Scheiber (*Deutsche Med. Wochenschrift*, Sept. 22, 1898) throws doubt on the inference usually drawn from statistics that syphilis is the principal, if not the only cause of locomotor ataxy. Cold, over-fatigue, worry, venereal excesses or injury, are now generally rejected as causes. As regards fatigue, however, Edinger and Helbing have recently shown that rats, if made to work hard and long, develop exactly the same lesions in the posterior columns of the spinal cord, and in the nerve roots, as occur in tabes. Statistics, in this case, as a rule depend on the patient's word, and are, therefore,

untrustworthy. The following facts ought to outweigh theories: (1) In many countries (Japan, Bosnia and Herzegovina, Central Asia, Abyssinia, &c.) syphilis is exceedingly common, while tabes is very rare, or altogether unknown. (2) Tabes is rare in prostitutes, who have mostly had syphilis. (3) Several cases are known where tabes developed in *virgines intactæ*, and where, from the circumstances, syphilis could be excluded with certainty.

Diphtheritic Noma.—Freymuth and Petruschky (*Deutsche Med. Wochenschrift*, Sept. 22, 1898) publish a case of cancrum oris occurring in a boy aged 8 years, who was in the sixth week of a severe attack of typhoid fever, in which Widal's reaction was present and typhoid bacilli were found in the urine. In the necrosed mucosa Petruschky found, besides what he held to be harmless saprophytic vibrios, cocci, and spirilla, also typical diphtheria bacilli, though these were very slightly pathogenic for guinea pigs. The child, after being at death's door, recovered with eight injections of diphtheria antitoxin, in all 9,500 units. The writers draw attention to the importance of diagnosing diphtheritic noma early, with a view to its treatment by antidiphtheria serum. Though the causal relation of the bacilli to the disease was not actually proved, they believe it to be a not uncommon occurrence, since, earlier in the year, they published (MEDICAL AND SURGICAL "REVIEW OF REVIEWS," vol. I, p. 153) a case of noma of the vulva, in which diphtheria bacilli were found, and which recovered under antitoxin.

The Painless Treatment of Cracks in the Nipples.—At the meeting of the Obstetrical Society, held on Nov. 10, a paper was read by MM. Maygrier and R. Blondel, upon the Treatment of Forty Cases of Cracked Nipples at the Charité Hospital. They had dressed the cracks with orthoform, which brought about complete anæsthesia during suckling and kept the cracks aseptic. The application of the powder causes only slight smarting. The infant was put to the breast a quarter of an hour afterwards, and sucked eagerly, as orthoform has neither taste nor smell. The anæsthesia persists for some time. MM. Maygrier and Blondel made trial of orthoform powder alone, of orthoform followed by a moist

dressing of boric acid, and finally with a strong alcoholic solution of orthoform dropped into the cracks. They considered this last method the best, for it caused no more initial smarting, but it quite did away with infection of the breast, probably because the solution was able to penetrate into the recesses of the fissures.—*Lancet*, Nov. 19, p. 1369.

Blue Nasal Secretion.—At the annual congress of the French Society of Otology and Laryngology, M. Molinié, of Marseilles, related the case of a young woman, aged 25, in whom, after a severe attack of grippe, there occurred a discharge of blue secretion from the nose. In the beginning the discharge was generally viscous and colourless. Several times during the day, however, the mucus was streaked by lines of blue as deep as methylene blue. Examination of the nasal fosse demonstrated that the source of the secretion was the right middle meatus.

A short, squat bacillus with rounded extremities, coloured by methylene violet and gentian-violet and retaining its colour under the Gram reagent, was found. Although cultures did not yield the characteristic blue colour, it is very probable that this case of blue chromorhinorrhea was due to the development of a pyocyanic colony in the frontal sinus of the right side.—*Revue Hebdomadaire de Laryngologie, etc.*—*St. Louis Med. Jour.*, Nov.

The Treatment of Burns with Chlorate of Potash.—Larger (*Gazette des Hôpitaux*, Oct. 27, p. 1131) employs cold solution of chlorate in local or even general baths immediately after burns. In case of urgency all that is necessary is to throw the crystals into cold water and agitate a little; in consequence of its feeble solubility the salt dissolves only to the required degree. The remedy is efficacious in even deep burns, but the action is particularly evident in the erythema of superficial burns. Relief is immediate.

Such is the treatment at the beginning when pain is dominant. Later, the method varies according to the depth of the burn. If deep, it is treated with dressings, like an ordinary wound; if superficial, compresses of chlorate of potash are continued until the end, but they are covered after one or two days with mackintosh.

Chlorate of potash has the advantages of being a feeble antiseptic, and not only non-irritant, but soothing. Administered in large doses it is toxic, but used in this manner it is absorbed in only small quantities. During twenty-eight years M. Larger has employed it at all ages without accident.

The Treatment of Bronchitis.—D. J. Leech, of Manchester, (*Practitioner*, May, 1898). In acute bronchitis of adults a combination of acetate of ammonium, spirit of nitrous ether, and ipecacuanha or antimony is commonly used. But an error is often made with regard to dose. The quantity of acetate of ammonium is usually too small—a drachm to a drachm and a half every four hours. Less than two drachms does not act on the skin or give the general relief which often results from a larger dose in the early stage of acute bronchitis. It is better to begin with doses of three drachms, and to increase to six drachms if the skin does not act freely. Marked relief in breathing often, though not always, accompanies the diaphoresis. Spiritus ætheris nitrosi is also very commonly given in doses too small to be of value. The spirit of nitre in many surgeries is largely devoid of the active ingredient, it is apt to decompose when the drug is long kept. Drachm doses of spirit of nitre should be given, but they occasionally give rise to eructations, and there are people who cannot take it without great discomfort. In acute bronchitis in young children where the temperature runs high and a few scattered rhonchi over the lungs foreshadow further troubles, he has seen more advantage from antipyrin than from acetate of ammonium. After a five-grain dose to a young child five or six years of age profuse perspiration followed by a very marked improvement often occurs. He has tried to determine the comparative value of ipecacuanha and small doses of antimony in acute bronchitis. Antimony, in doses of one-twentieth of a grain, is of great service when there are abundant small basic moist sounds, and the breathing is oppressed; when there are dry rhonchi all over the chest, with irritable cough, ipecacuanha is more useful than antimony.

In chronic bronchitis, ammonia, senega, squill, and ipecacuanha are the drugs most commonly

used; digitalis and strychnine being given where there is evidence of failing or defective cardiac or respiratory organs. Though the writer has much faith in carbonate of ammonium, he believes it often fails to benefit a patient owing to the manner in which it is given. He not infrequently finds patients suffering from severe chronic bronchitis taking three to five grains of ammonium carbonate, or ten to twenty minims of aromatic spirit of ammonia, every four hours. Such small doses probably exercise a beneficial influence on the stomach by their carminative and antacid action, but he has never been able to satisfy himself that any influence on the circulatory and respiratory organs is produced by them. Such a dose as three grains of carbonate of ammonium must, when taken into the stomach, be rapidly converted into a chloride, and often five grains, given at intervals of several hours, can leave little margin for such absorption of ammonia as shall benefit the chest organs. It does not seem likely that doses of ten to twenty drops of aromatic ammonia, given at long intervals, can produce any other than carminative effects. On the other hand, he has seen ten grains of carbonate of ammonia, given every hour or two, cause distinct quickening and increased strength of the pulse. It is not so easy to determine the effect of ammonium carbonate on the respiratory organs; nevertheless, he thinks he has observed a favourable influence, the respiration being deepened, and the expectoration more easily raised. Ammonia is very diffusible, and is doubtless quickly absorbed. There is every reason to believe that it is rapidly changed and excreted. It seems, therefore, that three to five grains of carbonate of ammonium, given at intervals of four hours, can hardly be expected to exert any curative influence where it is necessary to stimulate the respiratory centre, and promote expectoration in a serious case of chronic bronchitis. To produce this effect it should be given at short intervals. The drugs with which ammonia is frequently combined—squill, senega, &c.—are not advantageously given at very frequent intervals; moreover, the combination of ammonia with these drugs results in an unpleasant mixture, the nauseous taste of which is not easily concealed.

The most effective and convenient method of giving ammonium carbonate is to dissolve it in

water and give the solution in milk. If 60 grains be dissolved in 6 oz. of water, a tablespoonful (5 grains of the carbonate) can be given every hour or two, according to the nature of the case, in the milk which is taken by the patient. A tablespoonful of such a mixture can be added to 4 oz. of milk—not indeed, without making its presence perceptible, but without giving the milk a taste to which the patient will object. Indeed, many patients seem singularly insusceptible to the presence of carbonate of ammonium, and it is often possible to put 5 grains of carbonate of ammonium to 2 oz. of milk without any objection being raised. This method of giving ammonium carbonate in milk is specially advantageous when we wish to give strychnine as well as expectorants, for the addition of carbonate of ammonium to a mixture containing strychnine tends to throw down the alkaloid. The writer also points out that the presence of ammonium carbonate in the milk is advantageous because of its antacid effects, and in some cases milk agrees best when the ammonium carbonate is present. Aromatic spirit of ammonia cannot be well given with milk; the mixture is not agreeable.

One advantage of separating the administration of carbonate of ammonium from that of the other drugs is that we can give the latter beneficially without thereby losing the good effect that may be obtained from carbonate of ammonium. Senega and squill given at short intervals keep the stomach in a constant state of irritation. Senega is a somewhat remarkable drug. Nothing we know as to its active constituents enables us to understand how it produces expectorant effects. Its activity seems to depend on the presence of senegin, one of the saponin substances. Senega has maintained its reputation as an expectorant for so long a time that we can hardly doubt it must have some value. It may, perhaps, act through its influence on the stomach, on the mucous membrane of which it acts as a distinct irritant, its effect being somewhat prolonged. Because of its irritating effect it is undesirable to give this drug at intervals of less than four hours.

The efficacy of squill in bronchitis is much questioned, especially on the Continent, where this drug is looked upon rather as a cardiac tonic than as an expectorant. But the latter property is the more important. Dr. Leech believes it is useful in all forms of chronic bronchitis, both in the early and

late stages. When there is much dyspnea, however, and evidence of accumulation in the bronchial tubes, ipecacuanha is of more service if given in large doses. But these doses should not be very often repeated. Large amounts can sometimes be taken with advantage.

In conclusion, in reference to the use of oxygen inhalation, an objection to its use is made on the ground that it is not a really curative agent. This is true, but the inference that it is not worth giving is fallacious. It does remove cyanosis, and a continuous condition of cyanosis must be an evil. His feeling is that the inhalation of oxygen is generally commenced too late. He believes its early use prevents the advent of that pronounced cyanosis so often seen, which, once established, may be only slightly benefited by oxygen. It thus gives patients an additional chance of life, and furthermore in most cases it gives marked relief.—*Therapeutic Gazette.*

Boulimia.—On August 27 an inquest was held at Plumstead upon the body of William Ward, aged 84 years, an army pensioner, who died from asphyxia. At the post-mortem examination three pieces of meat, measuring in all 12 in. in length, were found in the deceased's "throat." Evidence was given that he was always a gluttonous feeder and in the habit of bolting his food. His daughter-in-law said that she used to mince his food, but that even then he would bolt such large spoonfuls that he had to gasp for breath. A verdict was returned of "Accidental death." Instances of ravenous appetite are not uncommon, constituting the condition known as boulimia or bulimy, moreover this craving for food substances is sometimes associated with another condition known as polyphagism, when the sufferer eats pins, string, broken bottles, and other indigestible articles. The *Lancet* for May 5, 1894, commented upon the death of a man in the London Hospital whose stomach was found after death to be full of a heterogeneous mass of these things. Certain tribes in South America are known as earth-eaters, from the habit they have of filling their stomachs with clay, and the custom of gorging is not uncommon among those who live a precarious life. In 1799 there was a French prisoner in England, by name Charles Domery, one of nine

brothers who with their father were all remarkable for voracious appetite. One day he was allowed as much to eat as he liked and between 4 a.m. and 6 p.m. consumed 4 lb. of raw cow's udder, 10 lb. of raw beef, 2 lb. of candles, and five bottles of porter. The narrator remarks: "It is also to be observed that the day was hot, and not having his usual exercise in the yard, it may be presumed he would otherwise have had a better appetite." We fancy the custom still exists in some parts of the country of having hasty pudding eating matches, and at a certain college in Oxford the following rite obtains or used to do twenty years ago. On Mid-Lent Sunday the first lesson in the evening is Genesis xliii., which gives an account of Benjamin's mess, which was five times as great as any of the other's. Furmenty was always served in Hall on that evening, and the junior man at each table was considered as Benjamin and served with an enormous helping. If he ate it all he could "sconce"—i.e., fine the whole table in sherry—if he could not he was himself fined. When this custom originated no one knows, but it is probably like so many other old customs a remnant of paganism with a veneer of Christianity over it.—*Lancet*.

Tetany in Dilatation of the Stomach.—Sievers (*Berliner Klin. Wochenschrift*, August 1 and 8, 1898) reports two fatal cases of tetany. Tetany occurs most often in gastro-enteric disorders, though it is not limited to them. In both the writer's cases it was associated with extreme dilatation of the stomach, caused by pyloric obstruction from the scars of old simple ulcers. In both the women, who were 21 and 42 years old, it began suddenly with cramps and pains in the limbs, and proved fatal within a few hours. There were carpo-pedal spasms, opisthotonos, tonic contractions in various muscles of the body, and fever. The abdominal muscles were flaccid. There was no trismus at first, though in one case it appeared towards the end, which was preceded also by cyanosis and unconsciousness.

The connection between tetany and dilatation of the stomach has lately aroused considerable attention. Though very rare, there are nearly forty known cases. The combination is extremely fatal, the mortality being about 70 per cent. The etiology of tetany is obscure. That it is reflex is

supported by the fact that it occurs in conjunction with intestinal worms and other irritants. Collier (*Lancet*, Vol. I., 1891, p. 1251) produced an attack by washing out the stomach, and others have seen the same effect by simply percussing over it. Frankl-Hochwart, from some of its symptoms, such as fever, &c., and from the fact that it occurs chiefly during certain months—December to April—supposed it to be a specific infective disease. The latest theory is that of Bouveret and Devic, who find that tetany of gastric origin usually occurs in patients suffering from hypo-secretion of hydrochloric acid, and have concluded that it is a complication of the chronic form of Reichmann's disease. Sievers has been able to collect twenty-seven fatal cases of tetany with gastric dilatation, which were examined post-mortem, and finds that in most cases the dilatation was secondary to stricture of the pylorus or duodenum from ulcers or their cicatrices. This might be thought to support the views of Bouveret and Devic, as it is precisely in such cases that hyperchlorhydria occurs, but occasionally hydrochloric acid is found, by analysis, to be completely absent. Sometimes the stricture is due to cancer, when according to modern views hydrochloric acid is deficient. The writer believes the most satisfactory theory to be, that which explains the tetany by an anto-intoxication from the alimentary canal.

Xerostomia, or Mouth-Dryness.—Since the publication of the earlier cases of this somewhat rare affection by Mr. Jonathan Hutchinson and the late Dr. Hadden, in the *Transactions of the Clinical Society of London* in 1888, some additional cases have been observed. Professor Fraser (*Edin. Hosp. Rep.*, 1893, Vol. I.) describes the case of a young woman who had suffered from dryness of the mouth for eighteen months. A special feature was associated dryness of the nose and eyeballs, so that she could not shed tears. A tabulated account of all the cases recorded up to 1893 is given. Since that date a few further cases have been recorded. At a meeting of the Clinical Society of London, February 6, 1895, Battle (*Brit. Med. Jour.*, London, February 16, 1895) showed a woman who had suffered for five years from mouth-dryness, which was associated with intermittent

attacks of parotitis. Every three or four weeks during the last two years the submaxillary glands had become enlarged.

Dr. Thomas Harris, of Manchester (*Am. Jour. Med. Sc.*, Phila., March 1898), has reported another case, which he had previously shown in 1894. Both parotid glands had been enlarged during the three years in which the mouth-dryness had existed. They were uniformly enlarged and of firm consistence, and pain and tenderness were entirely absent. The orifices of the ducts appeared natural; firm pressure along the course of each expressed glairy mucus. There was no associated enlargement of the sublingual or submaxillary glands, nor was there any affection of the lymphatics. In this patient there was also a slight dryness of the mucous membrane of the nose, and both taste and smell were interfered with. There was an arrest of secretion of all the buccal glands. The patient, as in the majority of these cases, was a woman. Treatment by tonics, jaborandi, and the faradic current gave no relief.

In the *Lancet*, April 23, 1898, another case is reported by Dr. Sharp, of Whitby, in which a single woman, aged 41, had suffered for eighteen months from constant dryness of the mouth. Here certain features which were present in the previous case were absent; there was no interference with the secretion of tears, no enlargement of the parotid glands, no depreciation of the sense of taste or smell, and little, if any, dryness of the nose. The patient reported that she was improving with medium doses of mercuric iodide and quassia.—*Edinburgh Med. Jour.*

Rhizomelic Spondylosis.—P. Marie (*Rev. de Méd.*, April 10, 1898) describes under this title a morbid entity, of which he has himself seen three examples, and has collected three cases from literature. As the name implies, the disease consists of ankylosis of the spine and of the limbs where they join the trunk. The spine is ankylosed, and there are bony outgrowths from the vertebræ which can be felt on the bodies of the cervical vertebræ when the fingers are introduced into the pharynx. The spinal ankylosis is more marked in the lumbar region and less in the neck. The spine becomes fixed in flexion, and hence considerable kyphosis results. The hip is more affected than the shoulder

and is the only one in which true ankylosis results. In the shoulder there is very considerable limitation of movement; the arms cannot be raised to a right angle with the trunk. Although the patients do not complain of loss of movement in the knees, they are affected. The ribs become fixed, and respiration becomes abdominal. The thorax and the pelvis become markedly flattened. The nodes described by Bouchard occur on the fingers. All the cases have been in men, and the disease usually begins in early adult life. Rhizomelic spondylosis differs from severe cases of chronic rheumatoid arthritis with ankylosis of the spine in not affecting the smaller joints. In hereditary traumatic kyphosis—a condition described by Marie and Astié—the kyphosis is curvilinear, and there is no affection of the joints. There is no evidence of any infection such as gonorrhœa. Marie has discovered a specimen in the Musée Dupuytren, which is probably an example of rhizomelic spondylosis. The spine is ankylosed, and shows bony growths and ossification of the supraspinous ligament, while the hip-joints are affected. Bricon's case of multiple exostoses, hyperostoses, and synostoses of the spine in a cat probably belongs to the same category.—*Brit. Med. Jour.*

Treatment of "Black Eye."—Charles H. May (*Medical Record*, New York). The treatment of contusions of the lids depends upon whether the patient is seen early, when there is considerable swelling, or not until later, when the discoloration is the prominent feature. If he is seen early treatment consists of cold compresses or cooling or evaporating lotions. With these swelling and discolouration can be diminished, though not prevented entirely. If the patient is seen later hot compresses and massage are indicated to hasten the disappearance of the discoloration. Cold compresses are to be applied continuously at first, but not by means of an ice-bag or a piece of ice wrapped in a handkerchief and applied directly to the swollen lids, since these furnish too intense and too constant cold. Small compresses of lint or flannel, fourfold or sixfold, measuring 1 and 1½ inch in diameter, are to be cooled upon a block of ice and then transferred to the lids. Several compresses of this sort are placed upon the ice and an exchange between the warm one on the

lids and a cool one from the ice is effected every minute or two. The cold compresses should not cover the nose, since acute coryza may be produced. They are to be applied during the first twenty-four hours, either continuously or every second or third hour for an hour at a time, depending upon the amount of redness and swelling. The sensations of the patient are usually a guide in determining the proper amount of cold; when the compresses are used too continuously they will become uncomfortable. Cooling and evaporating lotions are of service, though less potent than iced compresses. Both are to be applied cold, the compresses being wrung out and changed frequently. After twenty-four to forty-eight hours, when the swelling has subsided, the discolouration will show itself in a more pronounced manner; the lengthy duration of this stage can be cut short by hot applications and by massage. Flannel cloths are to be wrung out of hot water—as hot as can be borne—and allowed to lie upon the lids, being changed every minute or two; they are continued for an hour at a time, and applied three times a day, or oftener if it is especially desirable to hasten the return of the lids to a normal condition. When the skin is very sensitive, especially in women, a little white vaseline or any bland salve should be applied to the eyelids previous to the use of hot compresses, to prevent soreness and irritation of the skin. Massage is a very satisfactory means of causing a rapid disappearance of the discolouration. The area involved is smeared with the ointment of the yellow oxide of mercury or white vaseline, and then gentle massage is practised for five or ten minutes at a time, or longer, several times a day. If it is particularly desired to cause a very rapid disappearance of the blood stain, the hot compresses may be used continuously, and the massage for a number of hours. By these means the disfigurement may be almost, if not entirely, removed within twenty-four hours, or even sooner, after the subsidence of the swelling.—*Brit. Med. Jour.*

Hysteria in a Male Simulating Chronic Ileus.—Strauss (*Berliner Klin. Wochenschrift*, Sept. 19, 1898) reports a case where a man, aged 29, after an accident in which one of the left ribs was broken, suffered from constipation. Ever since

then he had suffered from chronic ileus with occasional attacks of apparently complete obstruction, with fœcal vomiting, &c. He had been in a number of hospitals, and laparotomy had been twice performed for obstruction, without, however, any abnormality being found. While in Senator's clinic he presented all the symptoms of chronic intestinal obstruction. At the same time he was evidently very neurotic; thus, there was anæsthesia of the left leg, the pharyngeal reflex was absent on the left side, and there were many other hysterical manifestations. This agreed with the histories taken in other hospitals, especially with the fact that after the two laparotomies he was cured for a time. It was difficult, however, to decide in what causal relation the various symptoms stood to the hysteria. Suddenly, after being treated for five months, the patient had a typical hysterical attack, when the enormous tympanites, which had persisted the whole five months with no evident improvement, disappeared, leaving the abdominal wall flaccid. Thirteen days later he left the hospital able to walk, and purgatives produced a daily evacuation, though previously they had had no effect. Strauss discusses the possible pathogenesis of the meteorism in detail, but leaves the question open.

Paroxysmal Hæmoglobinuria Combined with Urticaria "A Frigore."—At the meeting of the Société Médicale des Hôpitaux held on February 18th, M. Lucien Roques presented a very exceptional and interesting case. A man, aged 33 years, in good health, had suffered for three years from paroxysmal hæmoglobinuria. The attacks were always produced by exposure to cold, to which he was extremely susceptible. A momentary draught or merely getting out of bed would produce one. They were accompanied, especially when intense, by an icteric tint of the skin. The case showed a peculiar phenomenon which has not been previously described. If a portion of the skin was exposed to cold for a short time (a minute or half a minute was sufficient) by any means—for example, by the ether spray or by the application of ice or of a metallic body—a pruriginous urticarial wheel surrounded by a rosy band appeared in two or three minutes. It attained its maximum in four or five minutes, and disappeared in ten or fifteen minutes, leaving a yellow patch of œdema which

lasted for two hours. When the œdema passed away there still remained a yellowish tint which persisted for about twenty-four hours. The patient for some months had noticed occasionally that the parts of his body exposed to cold became swollen. Apart from this effect of cold dermatographia could not be produced. M. Roques endeavoured without effect to produce the phenomenon in a number of cases of nervous diseases including hysterical and organic affections of which some presented already vaso-motor disorders. He also failed in several patients who were the subjects of dermatographia. The existence of urticaria *a frigore* in a small number of cases of paroxysmal hæmoglobinuria has been described, but not the phenomenon in question, which is, in fact, factitious urticaria *a frigore*. In the *Lancet* of July 26 and Aug. 2, 1879, Dr. Stephen Mackenzie published the case of a child, aged four and a-half years, the subject of paroxysmal hæmoglobinuria, who, under the influence of cold, was attacked with shivering, generally accompanied by an eruption of large patches of the urticaria. Several writers have studied the relations of dermatographia to cold. Mesnet found in one case that the application of ice hindered the appearance of the wheals, and Gull, Michelson, and Féré obtained similar results. The phenomenon described by M. Roques is therefore dissociated from ordinary dermatographia. The yellow colouration of the wheals was evidently due to local transudation of hæmoglobin. The case, therefore, is evidence in favour of the view that paroxysmal hæmoglobinuria is due to the setting free of hæmoglobin in the blood-vessels—a direct effort, no doubt, of cold on the red corpuscles. The paroxysmal hæmoglobinuria arises from special susceptibility of the blood to cold, and the urticaria from special susceptibility of the vasomotor system. These susceptibilities appear to be independent, and are only exceptionally combined in the same individual with the results described.—*Lancet*.

Veal Pie Poisoning.—Paul Bowes, M.D., Harold Ashton, L.R.C.P. & S. (*Brit. Med. Jour.*, Nov. 5, p. 1456).—A confectioner made a batch of 160 veal pies, which were sold. 47 of those who ate them were made ill, and 4 died. The "incubation period" between eating the pies and the onset of the symptoms was fairly definite,

from six to eight hours in most cases. The shortest "incubation period" was three hours, and the longest twenty-nine hours.

GASTRO-INTESTINAL SYMPTOMS.—In all cases diarrhœa was a prominent symptom; in some of the milder cases only a few very loose motions were passed; in the other extreme there was almost a constant evacuation of the bowels, from the onset to death or convalescence. There was considerable griping, but in only a few of the cases was the pain very severe. The fæces were as a rule watery. They were grass-green at the commencement, but soon became very dark-green. In some blood was passed in small quantities. Vomiting occurred in all but two—at first yellowish-green; afterwards, if persistent, merely the contents of the stomach. Intense thirst was complained of. The tongue was dry, dark-brown, thickly furred in the severe cases; furred but moist in the less severe. Herpes of the lips was fairly common, and in one or two a transient rash was present, with, in some cases, subsequent desquamation of the cuticle.

TEMPERATURE.—In all adult cases but one shivering was a most marked symptom, and whenever seen in the early stages the temperature was invariably raised. In some cases it bordered on hyperpyrexia; in most it ranged from 100° to 101°.

GENERAL SYMPTOMS.—Weakness of circulation was a most prominent feature. In the severe cases it was extreme, and lividity and coldness of extremities came on rapidly. In the mild cases, even for days afterwards, the patients felt tired and weary.

NERVOUS SYMPTOMS.—Severe cramp was rare; some complained of pains and stiffness in the calves of the legs, as if they had had cramp. Some had twitching pains in the legs. Headache was not usual. Drowsiness was very marked in at least two cases, but many were restless from exhaustion.

TREATMENT.—Practically resolved itself into the prevention of collapse. In the worst cases, medicines, effervescing, or otherwise, were not retained. A mixture containing aq. sulph. dil., bismuth subnit., liq. morph. mur., and spir. chlorof. agreed well with the milder cases.

A necropsy in a fatal case showed patches of congestion of the mucous membrane of the small intestine, becoming more marked and frequent descending the intestines. The large intestine contained green fluid, and the lining membrane was throughout highly congested.

The pies were most virulent on the second and third days after cooking. Those which were eaten on the same day and the first day after cooking seem to have caused little or no ill-effects. No one complained of the taste or appearance of the pies, which had no smell whatever. The usual signs of a cold veal or pork pie being over-kept are: 1. The jelly liquefies and the bottom of the pie becomes soft. 2. The meat becomes detached and loose in the paste. 3. A whitish mould appears on the meat, which may smell sour.

Fatal Wasp Sting.—F. H. Cooke, M.R.C.S., L.R.C.P. (*Brit. Med. Jour.*, Nov. 5, p. 1429). A strong, healthy girl, aged 24, was stung by a wasp in the hand. A few minutes afterwards her face was very red. She complained of feeling numb all over, and of losing her sight; she then fainted. (These symptoms of numbness and blindness had also occurred on a previous occasion when she was stung.) Her face turned suddenly pallid and she expired in about twenty-five minutes. Well-authenticated cases of death due to syncope from wasp sting, &c., are rare.

Pressure Pouch of the Œsophagus.—An excellent article by Mr. Butlin (*Brit. Med. Jour.*, Jan. 1, 1898) summarises our knowledge of this condition. He has seen six patients suffering from the symptoms of pressure-pouch of the Œsophagus, and thinks that the condition is not so rare as has been generally imagined. Certain it is that the symptoms of the pouch are not generally known, and that it has been mistaken for pouching of the Œsophagus above a stricture, whether innocent or malignant.

True pressure-pouch of the Œsophagus is practically always situated at the back of the junction of the pharynx with the Œsophagus; it opens into the gullet by a longitudinal opening, about an inch in length; it is more frequent in males than in females, and is not generally noticed until after forty years of age. Return of fragments of un-

digested food is the one constant symptom in every case—not immediately after the food has been taken, but many hours, or even days, afterwards. Pressure on the side of the neck in the posterior triangle (usually on the left side) causes fragments and liquids to return into the mouth. A bougie is arrested at a distance of about nine inches from the teeth. If the bougie be made of metal and slightly curved, its end may be made to project, so that it can be felt and seen, in the side of the neck (almost always the left side) behind the sterno-mastoid muscle. The pouch can be removed by operation, and the patient is then not only relieved of distressing symptoms, but also of the fear of death from slow starvation. But the operation is not free from difficulty and risk. A successful case is recorded in the paper already mentioned, and Mr. Butlin had previously published another in the *Medico-Chi. Trans.* vol. lxxvi.

A case of pressure-pouch is recorded by G. A. Wright and R. Smith in the *Brit. Med. Jour.* for April 9, 1898, but in this instance the food could be returned by pressure on the *right* side of the neck. By emptying this pouch after every meal the patient has remained comfortable, and has been able to dispense with an operation for the present.—*Practitioner.*

Spinal Meningitis Complicating Measles.—Starck (*Jahrb. f. Kinderheilk. u. Physic. Erziehung*, vol. xlvii.) reports the case of a girl, 8 years of age, who had a typical attack of measles. On the second day of the eruption she complained of great pain on movement. The nurse could not turn the patient on her side, because of the extreme tenderness. All movements of the legs and arms were followed by muscular spasms. The skin of the legs and arms was hyperæsthetic. The neck was stiff and the head slightly retracted. The temperature was 101° F. On the same evening there was retention of urine, which lasted several days. On the fifth day of the nervous symptoms the patient was able to pass urine, but with pain. On the seventh day the arms were free from pain; the legs were still attacked with painful spasms when touched. In a fortnight the child was able to walk a little; the legs were still stiff but not painful. The knee-jerk was exaggerated. Micturition was painful, and the bowels only acted after

purgatives. Ultimately the patient recovered. Measles seemed to be the only possible cause of this condition; all other diseases were carefully excluded, and the child's previous health had been excellent. The writer could not discover a similar case after an exhaustive search.—*Brit. Med. Jour.*

The Value of Hydrochloric Acid in Sciatica, &c.—We stated how the value of hydrochloric acid in sciatica had been discovered in our first number (p. 41.) The following confirmatory observations are of interest:—

R. A. Bayliss, M.R.C.S., L.R.C.P., writes (*Brit. Med. Jour.*, Nov. 19, p. 1550.):—

Hydrochloric acid was applied over the course of the sciatic nerve or to the heels and feet, for the relief of pain in these parts in 26 cases. 16 had sciatica, which in most instances had defied every other treatment. Of these, 2 were completely cured, 11 were considerably relieved, and 3 were not improved. The remaining 10 patients were suffering from intractable pain in the heels and plantar region, the sequelæ of acute rheumatism, many gonorrhœal. Of these, 4 were quite cured, 1 was very much relieved, and 5 were not improved. The average number of applications was, for all the cases, 15. The duration of the treatment varied from one to five weeks. The strong acid of the *British Pharmacopœia* was painted on the skin at bedtime with a glass brush, in a series of lines about 2 or 3 inches long over the tender spots in the thigh and calf. When dry the limb was enveloped in cotton wool and loosely bandaged, and so left till the morning, when the patient was allowed to get up as usual. No vesication of the skin was produced, and the application was not attended with any pain. The acid may be applied every night or every other night, according to the effect produced on the skin, but it should be discontinued directly there is any sign of redness or irritation of the parts.

The Rôle of Secondary Infections in the Hæmorrhagic Forms of Eruptive Fevers.—Haushalter and Étienne (*Revue Mensuelle des Maladies de l'Enfance*, June, 1898), have found that in variola hæmorrhagic complications appear to be due to a secondary infection of the streptococcus. This organism has been found in pure culture in the blood and viscera of a child

dead of hæmorrhagic septicæmia appearing at the period of pustulation. But the most important argument is a distinct dissociation between variola and hæmorrhagic streptococcic septicæmia observed in a child affected with a discrete and very benign variola; during the convalescence fatal hæmorrhagic complications occurred as the result of the removal of the patient during the first period of the disease to a ward in which there were hæmorrhagic cases of the disease. Moreover, the hæmorrhagic form appeared to be independent of previous vaccinations.

A generalisation of these conclusions with reference to other infectious diseases was offered by a case showing a hæmorrhagic staphylococcic septicæmia during the desquamative stage of scarlatina.—*Amer. Jour. of Med. Sciences.*

Prolonged Diphtheria.—Golay (*Rev. Méd. de la Suisse Rom.*) publishes a case of diphtheria which, as regards the persistent presence of Loeffler's bacillus, lasted over 362 days. On March 11, 1896, the illness began; after an injection of antitoxin, the membrane had almost vanished on the 16th, and the child seemed quite well. Up till Aug. 6 virulent cultures of the bacillus were obtained (twenty-five examinations), at first pure, afterwards along with streptococci. From then till Sept. 2 cocci predominated, but a few short bacilli, proved experimentally to be diphtheritic, were present also. On Sept. 1 there was an acute relapse, with patches on the tonsils and B. diphtheriæ in pure culture. By Sept. 4, after an injection of serum (the third) the child was again cured clinically. On Sept. 10 no bacilli were found microscopically, and the cure was thought to be complete (just six months from the beginning), and no more cultures were made. However, on Oct. 22, there was another acute relapse, and the short bacillus was present with streptococci. By Oct. 28 nothing could be discovered under the microscope, and the patient, a boy aged 5½ years, was again looked upon as cured, and no further cultures were made till Feb. 5, 1897, when there was a third acute relapse when short bacilli and streptococci were found. These persisted after a fourth injection of serum till March 9. From then till Sept., 1897, the child kept well, but, as the parents would not consent to any more bacteriological examinations, it is doubt-

ful if he was finally cured even then. Golay thinks there can be no doubt that bacilli were never really absent. He concludes from this and other cases that (1) a fortnight's isolation after the disappearance of the false membrane, as advised in standard works, is totally inadequate; not till three or four examinations at intervals of a week have proved the complete absence of bacilli can cure be considered permanent; (2) the presence of Loeffler's bacillus between the attacks of angina does not alter the general health; (3) the prolonged presence of diphtheria bacilli after the disappearance of membrane is the rule rather than the exception, but probably this period is not so prolonged when there is an associated streptococcus infection; (4) local treatment should be abandoned entirely, as its only use is to torture the patient. In the case given above a good number of local applications recently recommended (by Loeffler and others) were tried thoroughly without the slightest effect.—*St. Louis Med. Jour.*, Nov.

Pemphigus and Measles.—Leo (*Vereins-Beilage der Deutschen Med. Wochenschrift*, Sept. 29, 1898) showed, before the *Niederrheinische Gesellschaft f. Natur. und Heilkunde*, three sisters, who, one after the other, were seized with pemphigus and measles. The pemphigus preceded the eruption of measles, which proved, in Leo's opinion, that the disease was not an abnormal form of measles (*morbilli pemphigoidei*), but a combination of the two infections.

Thrush of the Bladder.—V. Frisch (*Wien. klin. Woch.*, 1898, No. 39) records the case of an anæmic woman, aged 64, who had acute cystitis. She passed voluntarily 4 oz. of urine, and 12 oz. more were obtained by catheterisation, the last portions bubbling and containing a considerable quantity of gas (pneumatia). The urine showed a trace of albumen and 4 per cent. of sugar; it had a musty odour, and deposited a thick precipitate of white granular bodies, which were occasionally floated up to the surface by gas bubbles. Cystoscopic examination revealed more of these bodies attached to the wall of the bladder. Microscopically they consisted of a mycelium, which cultivation proved to be of the nature of thrush. The urine contained, also, yeast-cells, some bacteria, bladder-cells, and a very few pus corpuscles.

Senator has published a case in which pneumatia was produced by the alcoholic fermentation of diabetic urine, but in the present case the bulk of the gas resulted from the action of the bacterium coli. This has been previously recognised by Schnitzler. The bladder was washed out with a 1 in 1,000 solution of silver nitrate, and the condition was practically cured in four weeks. Thrush of the bladder has not previously been described. Whence it came in this case could not be determined; the only plausible theory was that it had previously affected the vagina, whence it had disappeared.—*Brit. Med. Jour.*

Enteric Fever Running a Prolonged Course: Chills: Profuse Sweating: Angioneurotic Œdema: Remarkable Elevations of Temperature without Complications.

—C. F. Martin, B.A., M.D., and B. D. Gillies, M.D. (*Montreal Med. Jour.*, Oct. p. 743) A man, aged 30, entered hospital on the 5th day of the disease with the usual symptoms of typhoid fever, the pulse being 90 and the temperature 104°. Under baths, the temperature was readily reduced, rising, however, to a maximum of 102° or 103° each day during the first ten days. Suddenly, on the 15th day, the temperature rose to 105° and the patient had a severe rigor followed by sweating. On the 23rd and 24th days the chills again recurred with profuse sweating. On the 26th and 27th days the temperature remained below 99.5° and the patient was apparently convalescing rapidly. On the following day again his temperature rose suddenly, and in forty-eight hours reached 104.2°. Rigors and sweating supervened, and he complained of severe pain in the right hypochondrium, for which no cause could be found. The temperature again subsided, but two days later very large swellings suddenly appeared over the left shoulder and left hip joint. These were red and tense, glistening, and tender. They entirely subsided in two days. From that time on to the 32nd day the patient seemed to be gradually convalescing, and by the 51st day the evening temperature attained the normal. But the temperature again rose and reached 104.2°. The fever subsided as rapidly as it had appeared and within a week was again normal. Once more, on the 64th day, the temperature rose from 98.2° to 105°; within

a few hours rigors and sweating reappeared. In two days the temperature was normal, which it remained.

This case is particularly interesting for it shows the uncommon complication of angio-neurotic oedema, and remarkable elevations of temperature due, not to any complication nor to typical relapse, but analogous to the temporary septic intoxications of the puerperal state. The fact that the pulse in the interval of these high temperatures remained slow and the general condition excellent, would seem to indicate that no serious complication had arisen.

Lupus Treated by Röntgen Rays.—Dr. J. Rudis-Jicisky (*Amer. X-Ray Jour.*, Oct., 1898), after treating a number of cases of lupus with Röntgen rays, in which very favourable results were obtained, has decided that the Röntgen rays constitute the best means for producing artificial inflammation, and converting unhealthy ulcerations into open healthy granulations. He reports the two following cases:—

First case was one of lupus erythematosus on the left leg, characterised by the appearance of pink patches covered with yellowish adherent scales. Having tested the tube with the screen, to see that it was in working order, and using an 8 in. coil, a series of short exposures were made. The healthy tissue was protected with stanoil, and the tube was placed at a distance of from 15 to 18 in. At first there were traces of brownish discoloration of the skin. After the first application the infiltration began to diminish. Later, general inflammatory action was established, and the unhealthy ulcerations assumed the appearance of healthy granulations. The patient was completely cured.

Second case.—Lupus vulgaris on the right side of the face, which began with the appearance of yellowish deep papules and gradually extended, forming irregular ulcerative patches. The Röntgen rays were used with marked beneficial effect.

Vicarious Urination?—Dr. Rice (*Canadian Lancel*, October, 1898) reports a curious case. The patient, aged 30, of a nervous temperament and rather weak intellect, three years ago had an attack of cystitis, with complete atony of the bladder, of three weeks duration, necessitating the use of the catheter during that period. The attack gradually

subsided, though considerable tenderness remained for some time. Twelve months after this attack, she suffered from involuntary twitchings, emanating from the dorsal region and extending over the whole body; there was considerable tenderness over the spine. These twitchings, or spasms, were so severe as to confine her to bed for several weeks. Accompanying this attack were discolourations of the right leg and thigh, extending almost entirely over the limb, but without tenderness. After a few weeks, they gradually disappeared, and the patient regained her ordinary health. A year ago, the atony of the bladder returned, and the patient was again obliged to resort to the use of the catheter three times a day, about half-an-ounce being drawn each time. The general health suffered, the bowels were constipated, appetite impaired, there were mucous patches in the mouth, and the breath was foul. Treatment failed to relieve these abnormal conditions; the twitchings returned and continued. The feet began to swell slightly, the secretion of the bladder gradually diminished, but was compensated for by an exudation of fluid from the anterior portions of the lower limbs between the knee and ankle. This fluid was voided regularly three times a day, the amount gradually increasing until it averaged from thirty to forty ounces per day. There was no abrasion or discolouration of the skin, and no oedema was present. The fluid simply oozed from the skin. The patient would realise that the flow was about to begin, and would place her feet upon a stool and a basin beneath her heels. The fluid was of an amber colour, similar to healthy urine, with a specific gravity of 1010. It had a strong smell of urine upon boiling, with a distinct ammoniacal smell after standing. Examination showed the presence of uric acid; albumin and sugar were absent. After this peculiar condition became established, the patient's health rapidly improved and became fairly good; so that she had little to complain of except the inconvenience caused by this peculiar phenomenon. This condition lasted about two months, when, after an unusually large quantity of fluid had been passed, it ceased altogether, and urine again began to pass through the urethra. The patient again became very ill, and spasms re-appeared accompanied by headache, swelling of the feet, and great

swelling of the face. These symptoms lasted about a week, then gradually disappeared, and the patient regained her usual health, which has continued until the present time. Dr. Pice vouches for the correct history of the case, and was present upon one occasion when the fluid was voided in the peculiar manner described. He naturally asks, Was this vicarious urination? If so, how is it to be explained? Through what channel did it travel? The fluid certainly stood the tests of urine, and its elimination enabled the patient to live.

Unilateral Excision of the Thyroid Gland in Graves' Disease.—Wolff (*Mittheilungen aus den Grenzgebieten der Medicin und Chir.*, Bd. III. Hft. 1.) mentions the conflicting opinions which are held as to the value of unilateral excision of the thyroid gland for exophthalmic goitre, and reports some cases of his own. In one of these the result was brilliant. The woman, who at the time of the operation was extremely emaciated, and had derived no benefit from any drugs, five and a half years later was in robust health, and had had two children, though exophthalmus was still present. His nine other cases show that a favourable result may be expected, even in the worst cases, which have derived no benefit from medicine, though it does not follow in all. Thus, out of his nine cases, six were benefited, one had a severe relapse, and two died.

Splenectomy in Malaria.—Laccetti (*Giorn. Internaz. delle Scienze Med.*, Fasc. I, 1898) reports a case where he removed an enlarged malarial spleen. Six days later an intermittent fever appeared, which soon yielded to quinine injections. This was probably due to the sporulation of the malarial parasite, which, according to Pes, may remain latent in the blood for months. The patient experienced also violent pains in the long bones, which it is suggested were due to a vicarious action of the bone-marrow. Laccetti states that the simple congested spleens found in chronic malaria are reduced by quinine or vasoconstrictor drugs—such as arsenic, strychnine, ergotine—or electricity; when, however, there is a hypertrophic interstitial splenitis, splenectomy is indicated, especially if the enlarged spleen is painful.

Maragliano's Anti-Tubercle Serum.—Ulrich (*Therapeutische Monatshefte*, Oct., p. 547). Dr. Ulrich gives notes of 7 cases treated with Maragliano's serum, including 3 of tuberculosis of the lung alone, 2 in which both lungs and larynx were involved, one of Pott's disease with psoas-abscesses, and one of advanced tuberculosis of lungs, testicle, and ethmoid bone, with probable lardaceous disease. No very definite decision can be arrived at from the results recorded. The most marked influence of the remedy appeared to be exercised on the temperature, which became normal during the administration of the serum. In one case in which injections were practised on alternate days the temperature remained normal on the days on which the remedy was applied, but rose on the intermediate days. In only one case did tubercle bacilli cease to appear in the sputum: in another they were expectorated in clumps, as if the serum had had the effect of "agglutinating" them. No change was observed in the laryngeal affection in either case, but the patients in nearly all cases professed to feel some subjective improvement. In one instance an urticarial rash followed the injection, as is known to occur also after injections of anti-diphtheritic serum.

Röntgen Rays in the Treatment of Hypertrichosis.—Drs. Schiff and Freund (*Wien. Med. Woch.*, Nos. 22, 24, 1898) describe the removal of superfluous hairs by means of the Röntgen Rays. In order to avoid causing inflammation, they use a current which does not exceed a maximum of 2 amperes, the maximum tension being 11½ volts. The source of the light is placed at a distance of 20 to 25 centimetres from the skin to be subjected to the influence of the rays, which they do not use for a longer period than 10 minutes. The apparatus they use is supplied by M. Kohl of Chemnitz. (In the treatment of lupus vulgaris, when it is desired to produce inflammation, they use 3½ amperes, 12¾ volts, and a distance of 10 centimetres.) The treatment of two cases of lupus and seven of hypertrichosis is reported. In epilation, they obtained the best results after 17 to 30 sittings of short duration. In several cases, they noticed that, a day or two before the hair fell out, the skin showed a brownish discoloration, which disappeared three or four days later. In several brunettes, the hair, before it fell out,

became snow-white. The writers confirm the observations of Foster and others that the effect of the rays is cumulative. Jutassy has treated 40 cases of hypertrichosis by the Röntgen rays, and in several cases there has been no re-growth of the hair after a year.—*Amer. X-Ray Jour.*

Organisms Resembling Tubercle-Bacilli.

—Moëller (*Therapeutische Monatshefte*, Nov., p. 607). In seeking for bacilli which resemble that of tubercle, Dr. Moëller discovered on a species of grass, known in Germany as "Timothee gras" (*Phleum pratense*), an organism which seems to show almost, if not quite, identical characteristics with those of Koch's bacillus. It shows the same tenacity for the fuchsin stain, presents on culture-media very similar appearances, and produces when injected into guinea-pigs practically identical lesions. Another very similar organism was also discovered in the manure from a cow-house, and in the fresh excreta of cows, goats, and other animals. The writer names these two varieties respectively the "Timothee-bacillus" and the "Mist-bacillus" (*Dung-bacillus*). They form along with a few previously described similar organisms, and with the tubercle-bacillus of Koch, a botanical group of great interest. It is even possible that the Timothee-bacillus may be capable of the slight variation necessary to form a true tubercle-bacillus, and that it may thus constitute the source of tubercular disease.

Pancreatic Lithiasis.—Cipriani (*Therapeutische Monatshefte*, November, p. 617). The writer records a very interesting case in which it was possible to diagnose during life the existence of a Calculus blocking the pancreatic duct, and in which the condition was effectually relieved by treatment. The patient was a youth, aged 15 years, whose past history was unimportant, with the exception of an attack of malaria. He was suddenly seized one evening after supper with a "colicky" pain in the epigastrium. The pain was deep-seated, referred chiefly to the left hypochondriac region, just internal to the nipple-line, and radiated round to the left shoulder and spine. The patient also felt extremely hungry and thirsty. After lasting 2 hours the pain subsided, to return again after two days, this time accompanied by nausea and vomiting. Simultaneously the stools

were fatty, there was salivation, polydipsia, glycosuria, fever, and extreme weakness. These symptoms recurred at intervals of 48 hours. The patient became much emaciated; extreme hunger and thirst continued: the urine contained 0.50 per cent. of sugar. Examination of the fæces revealed on one occasion the presence of a small calculus, consisting of calcium carbonate. The temperature rose to 38.5°C (101.3°F) and the pulse to 120 beats per minute. The treatment adopted consisted of a diet of green vegetables combined with 30 grm. lævulose, equal to the amount of glucose lost in the urine; along with this were ordered gymnastics, baths and massage, and doses of hydrochloric acid, with a view to dissolve the concretion. This régime was entirely successful: thirst and polyuria disappeared, and the patient made a complete recovery.

On the Early Recognition of Pulmonary Tuberculosis.

—Meissen (*Therapeutische Monatshefte*, Nov., p. 589). The general mode of entry of the tubercle bacillus into the body is not yet ascertained with any certainty, but it appears probable that it may remain latent for some length of time in a lymphatic gland or elsewhere, before it gives rise to symptoms of lung-infection. It is most important to recognise this occurrence in its earliest stage and apply treatment at once. The earliest symptoms are often a feeling of weakness and disinclination for any exertion. Appetite may fail, and the disposition become irritable or depressed. Loss of flesh and anæmia are also suggestive symptoms. Pains in the chest, often at the apices of the lungs, are not infrequent in the early stage of the disease, owing no doubt to some slight involvement of the pleura: the pains may radiate to the arm and shoulder. Cough at first is usually dry and "hacking"; later, it may result in some mucous expectoration. It is often excited by deep inspiration. Tubercle bacilli may or may not be found early in the sputum: their absence cannot be relied upon as a proof that the disease is not tubercular, nor does their actual number appear to be of any value for prognosis. Loss of flesh is not a necessary accompaniment of early tuberculosis—in anæmic girls and other patients a fair development of fat is often found with it. Measurements of the chest, and especially of the "vital capacity"

are of considerable value. Good muscular development, again, is not by any means incompatible with phthisis, and many athletes appear to fall victims to the disease. In such patients breathlessness, palpitation, and cardiac irritability are not infrequently the earliest signs of the malady. Careful physical examination by percussion and auscultation are, however, the most certain means of diagnosing early tuberculosis of the lungs, and these old-fashioned means of diagnosis should not be neglected for the modern search for bacilli. The earliest signs are some defect of resonance at one apex, best detected by light percussion, and an alteration in the normal breath sound, which may be either fainter over the affected area, or sharper and clearer, or in some cases of a "cogwheel" character. The temperature of the patient must also be carefully noted, any evening rise being of importance. The mouth is a better place for taking the temperature than the axilla. An undue rise of temperature after slight exertion appears characteristic of phthisical patients.

The use of tuberculin for diagnostic purposes in human beings is not to be recommended, since apart from the uncertainty of the reaction produced, it appears liable to cause a lighting-up of old tubercular foci and consequent dissemination of the disease. Nor do the Röntgen rays prove of much assistance in early phthisis, though at later stages the existence of tubercular consolidation and caseation may be rendered visible by their means.

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THERAPEUTICS.

The Treatment of Arthritis by Hot Air Baths.—By T. Sydney Short, M.D. (*Brit. Med. Jour.*, Nov. 26, p. 1611). Attention has lately been drawn to the treatment of chronic joint affections by means of hot air locally applied, and it is claimed that great benefit accrues from the application of super-heated dry air by means of a special apparatus, which has been patented. Dr. Short has found that satisfactory results may also be obtained without special apparatus, beyond the apparatus in common use in hospitals for the administration of hot-air baths when profuse diaphoresis is indicated. The patient lies in bed between blankets. The tent which covers

him is made of two large cradles, covered first with blankets, then with mackintosh sheets, and then again with blankets. The coverings must be arranged at the top of the tent in such a manner that a small opening can be made to let out the hot air when it has become saturated with moisture. It has not been found necessary to make any counter-opening, as the entering air finds plenty of inlet between the blankets and the chimney of the heating apparatus. If the packing be too tight, a counter-opening must be made. The patient's neck should be wrapped as air-tight as possible. The cradles used are made of wire netting on a metal frame; they are inexpensive, and cannot take fire. The flue attached to the lamp passes through an opening in the blankets at the foot of the tent, and may be covered with asbestos or a wet cloth to protect the blanket. The lamp should be made without solder, because the excessive heat is apt to damage the connections, and to allow of the escape of some of the spirit, which will speedily ignite. A very convenient method is to replace the spirit lamp by a ring Bunsen's burner attached to a gas bracket by means of a long rubber tubing. This is safer than a lamp, and raises the temperature inside the tent more rapidly.

The blanket which has covered the body is removed finally to allow of free evaporation from the surface of the skin. The patient, therefore, lies quite nude inside the tent. The patient is wiped down after the bath, and wrapped in dry blankets for the rest of the day.

The estimation of the temperature inside the bath is not easy. The air in the upper strata near the top of the tent is always much hotter than that of the lower strata in which the patient lies. There may be a difference of 10° F., or even more. A long thermometer, with the index outside the tent, may be inserted through a small hole in the blanket near the side of the tent, so that the bulb is near, without actually touching, the patient's body.

As a rule, an opening need not be made till the patient breaks out in a good perspiration or complains of feeling too hot. If the temperature of the air be taken at this stage, it will be found to be from 120° to 130° F. The opening should now be made at the top of the tent. The feeling of excessive heat passes off rapidly, as the hot air saturated with moisture

passes away. This is the important point in the treatment, because, unless the moisture is got rid of, few patients can be found to stand a temperature beyond 130° F. On the other hand, if this is done periodically, the air in the tent is kept sufficiently dry to allow of the temperature being raised to 200° F. or higher. During the first bath keep the temperature at about 130° F. for twenty minutes, and then take the patient out, subjecting him to a greater heat on subsequent occasions.

This treatment is applicable to:—

1. Subacute rheumatic arthritis.
2. Subacute arthritis following acute rheumatism or gout, or consequent on a pyæmic condition such as gonorrhœal arthritis.
3. Chronic thickening from gout, rheumatism, or rheumatoid arthritis, associated with pain and stiffness on movement, with continual aching pains.
4. Impaired mobility following injuries to joints or to muscles in their neighbourhood; and cases of joint trouble from trophic causes or disuse.

An Apparatus for the Treatment of Headache.—Sarason (*Therapeut. Beilage der Deutschen Med. Wochenschrift*, Sept. 1, 1898) has constructed an apparatus which he calls a Migrainator. It consists of two pads which can be pressed firmly against the temples by an adjustable spring. The inventor got the idea from the fact that people with headache instinctively press their hands to some part of the head, generally the temples. He has found the contrivance very useful in a large number of cases. It is made by the firm of Schönlein and Co., of Munich.

French Society of Electro-Therapeutics.

—(Nov. 17, 1898.) M. Apostoli in the chair. *Cauteries and Lamps for Exploration*. M. Gaiffe showed cauteries and lamps with complete metallic mountings which allowed them to be heated before use. Their manufacture permitted a reasonable price.

Electrical Treatment of Hysterical Gastralgia.—Contribution to Franklinisation in Electro Diagnosis by MM. Apostoli and Planet.—In connection with a serious case of hysterical gastralgia of ten years' duration, rebellious to recognised modes of treatment and suspected to be of tabetic origin, which disappeared under

Franklinisation only, the following conclusions were stated:—

1. Certain gastralgias, manifestly hysterical, can simulate a precocious and often isolated symptom of early tabes.
2. Franklinisation is a valuable means of differential diagnosis.
3. Electrical (static) treatment rapidly reveals from the first hysterical states by showing peripheral perversions of sensibility, and the diagnosis is confirmed by their greater or less mutability.
4. The same treatment continued sufficiently cures hysterical gastralgia of which the diagnosis is thus a second time made clear by therapeutics.

The Treatment of Tapeworm.—Sasse (*Med. Weekblad*, Aug. 14, 1898) recommends copper oxide and male-fern as the two best drugs for killing tapeworms. Oxide of copper is given in doses of 1½ to 3 grains (4½ to 9 grains in the day) for several days. At the end of a week or a fortnight a purgative is given. The only restriction in diet is that the patient must avoid acid food. Extract of male fern is prescribed by Sasse to be taken early in the morning fasting. The day before the bowels should be opened by a dose of mineral water, and only liquid food should be taken. Castor oil is dangerous, as the oil aids the absorption of the male fern. Doses of over half an ounce are usually well borne, and it is best given in gelatine capsules.

The Treatment of Pneumonia with Digitalis.—Maragliano (*Gazz. degli Ospedali e delle Clin.*, No. 31, 1898) treats pneumonia with large doses of digitalis, not for the purpose of treating the symptoms, but with the idea of actually neutralising the pneumococcus toxin, in the same way as is done by the pneumococcus serum. The doses given are one drachm of digitalis in infusion the first twenty-four hours, and in a severe case another drachm in the second. Generally three to four drachms in infusion are given during the course of the pneumonia. If the pulse becomes infrequent the doses are diminished. These high doses are well borne by pneumonia patients, though poisonous for healthy people, because, according to Maragliano, the digitalis and the pneumonia toxins neutralise each

other. Bacteriological experiments showed that 1 cg. of digitalis added to 10 g. of a culture of pneumococci killed it rapidly, and even 3 mg. of digitalis was enough to inhibit the growth completely. This action was specific since the growth of other organisms was uninfluenced by the addition of digitalis, while, on the other hand, other alkaloids, such as cocaine, etc., in the same doses, had no influence on the growth of the pneumococcus. Further experiments showed that digitalis, when injected at the same time as a fatal dose of pneumococcus toxin into rabbits, neutralised its effect, and the animals lived.

Clinically it is found that digitalis acts on the fever and on the inflammatory process in proportion to its effect on the pulse. If this effect on the heart and the pulse is not obvious within twenty-four hours, the prognosis is bad. It is important to begin the treatment within the first three days of the disease.

Tuberculin R.—Schreiber (*Vereins-Beilage der Deutschen Med. Wochenschrift*, Sept. 15, 1898) reports the results of a seven months' trial of Koch's new tuberculin (T. R.). The patients (10) were all chosen as suitable for the treatment, and were in the first stage of tuberculous phthisis without fever or other complications. (1) The injections, 242 altogether, were often followed by tenderness or infiltration, but never by abscess. (2) A reaction showed itself by a rise of temperature thirty-one times with doses no larger than $\frac{1}{65}$ mg, and a general reaction without fever with still smaller doses. (3) Most of the patients improved subjectively, and gained in weight. (4) only four improved objectively and of these one, after the maximum dose of 20 mg. had been reached, still reacted to 1 mg. of the old tuberculin injected as a test, and had bacilli in the sputum; a second, though no bacilli were present, still reacted to the old tuberculin; the third and fourth did not react to the old tuberculin, but one of them still had bacilli in the sputum. (5) The following complications occurred during the treatment among those who did not improve: hæmoptysis in three (fatal in one), laryngeal ulcer, endometritis and parametritis, and hectic fever, followed by death. One case of lupus improved as regards one patch, while another patch remained unchanged. Schreiber thinks these results

are very like those obtained with Koch's original tuberculin, and believes the difference between Koch's reports and others, must rest on nomenclature; what Koch, for instance, calls the first stage of tuberculosis being not phthisis at all, but what many would call struma, and his second and third stage corresponding somewhat to what is usually called the first stage. In discussing Schreiber's paper, Lichtheim said it was too early to decide as to the real value of T. R. He had seen cases apparently cured by it. A man with diabetes was treated in Koch's institute for bacillary phthisis; on entering the Königsberg hospital he showed no signs of phthisis. He died from diabetes, and in spite of the unfavourable influence of that disorder, only healed tubercles were found in the lung.

The Treatment of Asthma.—Von Noorden (*Münchener Med. Wochenschrift*, Sept. 27, 1898) recommends atropin, which was introduced by Trousseau. Beginning with $\frac{1}{150}$ grain of atropin, the dose is increased to $\frac{1}{65}$ grain after two or three days. After the maximum of $\frac{1}{65}$ grain is reached, the dose is gradually reduced, the whole course lasting four to six weeks. Constant medical supervision is necessary, but no evil effect is observed, if the drug is given in this way. Though atropin does not influence the severity of the attacks, it lengthens the intervals between them very considerably, and, though it may not cure, causes lasting improvement, unless the case is complicated by emphysema or chronic bronchitis.

Orthoform in Intramuscular Injections of Mercury.—Loeb (*Monatshefte f. Praktische Dermatologie*, Bd. xxvii, No. 1) found that by mixing 5 to 10 per cent. of orthoform with a 10 per cent. solution of salicylate of mercury, the pain accompanying intramuscular injections for syphilis was prevented, or at any rate, relieved. There was some local pain with nausea 8 to 10 hours afterwards, but these troubles were never intense, or lasted for more than a short time. No unpleasant effects were ever observed.

Tetanus Treated with Antitoxin.—Beuthner (*Therapeut. Beilage der Deutsch. Med. Wochenschrift*, Oct. 6, 1898), reports another case of tetanus unsuccessfully treated with antitoxin. A

boy, aged five-and-a-half years, while playing barefooted in a damp meadow, cut his foot with broken glass. Tetanus followed in a very severe form, the incubation period being only five-and-a-half days. In spite of antitoxin being injected comparatively early (within twenty-four hours of the first symptoms) death resulted twenty-six hours later. Two injections of $2\frac{1}{2}$ c.c. each (= 503 tetanus antitoxin units) were given, the only result being a transitory improvement after the second.

NEUROLOGY.

Arterio-Sclerosis of the Brain.—Kovalevsky (*Neurol. Centralblatt*, No. 15, 1898, p. 674). Arterio-sclerosis, or atheroma of the arteries of the brain, has up to now been little studied as the cause of certain definite brain symptoms.

Grasset ("Du vertige cardio-vasculaire, ou vertige des artério scléreux," 1890), when speaking of chronic vertigo, recognises certain forms—the epileptic form, the sensorial form, or Menière's disease, the digestive form, and the cardio-vascular form or the vertigo due to arterio-sclerosis. The vertigo in the latter is either simple or accompanied by epileptiform fainting attacks. One of Grasset's patients had a pulse of 25–30 per minute, and, when the pulse became still slower, the patient had an attack of syncope. According to Grasset, the symptoms are caused by arterio-sclerosis of the vessels of the medulla oblongata.

Mendel ("Über den Schwindel," *Berlin Klin. Wochens.*, 1895) also looks upon vertigo as an early sign of arterio-sclerosis, and recommends prolonged use of iodide of potassium and ergotin.

Regis ("Neurasthenie et artério-sclérose," *Presse Méd.*, 1896) draws attention to the frequent occurrence of neurasthenia in arterio-sclerotic patients, even at a time when there is as yet no very marked arterio-sclerosis, noises in the ear, vertigo, disturbances of the vascular system, and bladder troubles being the most prominent symptoms. Probably both the neurasthenia and arterio-sclerosis are in these cases due to the same cause—namely, to the disturbances in the nutrition.

Hutchings (*State Hospitals' Bulletin*, 1896) looks upon the nervous symptoms noticed in arterio-sclerosis as due to disturbance in the nutrition of the ganglia-cells, caused by the thickening of the walls of the blood-vessels; hence the prominent symptoms are diminution of the mental activity, vertigo, attacks of syncope, and disturbances of speech. To recognise the early stage of arterio-sclerosis the aorta and the eyes should be carefully examined.

Lapinski (*Wratsch*, 1896) examined the large vessels of the base of the brain, and also the capillaries, and found the capillaries often affected with cloudy or granular degeneration.

Beyer (*Centralb. f. Nervenheilk.*, 1896) describes some cases of arterio-sclerosis which resembled general paralysis. The disease occurs between the ages 50–55, and commences with an attack of apoplexy, hence he calls it dementia apoplectia, and it differs from general paralysis by the attacks of dementia occurring at separate stages.

Arnaud (*Gaz hebdom.*, 1897) draws special attention to the similarity of the symptoms of arterio-sclerosis and general paralysis.

The writer gives three cases of his own:—

Case 1.—P., age 70. Eighteen months before he was seen he complained of loss of memory, vertigo (occurring in paroxysms and lasting only a few minutes), staggering gait, tinnitus aurium, and constipation. Nine months after the commencement of the disease the symptoms became worse; sleep was much disturbed; when he awoke in the morning he saw everything through a fog; he had a good deal of præcordial oppression; the vertigo increased, and was accompanied by attacks of syncope. The patient, who appeared strong and muscular, showed slight tremor of the tongue, the speech was somewhat indistinct; the temporal arteries were atheromatous, the retinal arteries were tortuous, the left ventricle slightly dilated, the second sound accentuated, the pulse was forty to fifty, the tendon reflexes were diminished, the pupils normal. Iodides, cardiac tonics, cauterisation of the spine in the cervical region, laxatives, and strict diet and recumbent posture were ordered. In a month the patient had greatly improved. Carbonate of soda and lactic acid, which were tried in the second month, had no effect, the treatment with iodides was

renewed. The patient greatly improved and returned to work.

CASE 2.—Male, age 67. A neurotic family history. Patient had syphilis thirty-five years ago; had influenza four years ago; soon after suffered from attacks of vertigo lasting twenty to twenty-five minutes, accompanied by fainting. He also suffered from tinnitus aurium, loss of memory, sleeplessness, and præcordial oppression. Eight months after he had an apoplectic seizure, with loss of consciousness, followed by right-sided paresis and aphasia, which disappeared after four days. Two months after he had a second apoplectic attack, not followed by paralytic symptoms. Patient appeared strong and muscular; the right pupil was smaller than the left, both reacted promptly. There were marked arterio-sclerosis, tortuous retinal arteries, dilatation of left auricle. The second sound was accentuated; the pulse was fifty-six to sixty, the reflexes were increased.

CASE 3.—A female patient had suffered for four years from noises in the ear, vertigo, sleeplessness, and failure of memory. Two years ago she began to suffer from more severe attacks, commencing with twitchings of the face, fainting sensation, and a feeling as if everything was moving around her. The attacks lasted from one to three hours, and terminated with vomitings. During the attack the patient heard well, and understood all that was said to her, but could not answer. After the attack she felt very faint. During the last twelve months the attacks occurred more frequently. The patient showed marked arterio-sclerosis, which was seen also in the retinal arteries. The left ventricle was enlarged; the pulse 60. Cardiac tonics and sodium preparations caused marked improvement in her condition.

The writer believes that some of the symptoms common to these cases, such as vertigo, sleeplessness, syncopal attacks, failure of memory, are due to the atheromatous process in the arteries generally, whilst a second group—failure of mental power, disturbance of speech, apoplecti form attacks, staggering gait—depends on the locality affected.

As to treatment he has tried without success that recommended by Rumpf (*Berl. Klin. Wochenschr.*, 1897), who, considering that in arterio-sclerosis salts of lime are deposited in the altered wall of the vessel, recommends (1) to diminish the

quantity of lime salts taken with food, and (2) to try and decalcify the arteries. He, therefore, recommends a diet which does not contain milk.—*Medical Chronicle*.

The Reflex of the Tendo Achillis in Locomotor Ataxia.—Babinski (*Gazette des Hôpitaux*, Oct. 25, p. 1121) two years ago drew attention to the diminution or abolition of this reflex in sciatica. According to him, in the normal state it is as rarely absent as the patellar reflex, if it is sought with the patient placed kneeling on a seat. In locomotor ataxia it has relations with the patellar reflex. M. Babinski divides the subjects of this disease into four classes:—(1) The most numerous, those in whom both reflexes are abolished on both sides. (2) Those in whom there is disturbance but not complete abolition of the reflexes—both abolished on one side, and preserved on the other, or the alteration "crossed." (3) Those in whom the patellar reflex is abolished or affected, and the reflex of the tendo Achillis normal. (4) Those in whom the patellar reflex is normal and the reflex of the tendo Achillis abolished or affected.

M. Babinski thinks that his observations show that the diminution or abolition of the reflex of the tendo Achillis has as great importance in the diagnosis of locomotor ataxia as Westphal's sign. In most patients there is perturbation of both reflexes; in the rare cases, where one only is affected, it is as often the reflex of the tendo Achillis as the patellar.

DERMATOLOGY.

An Eruption in the Mouth as an Early Symptom of Measles.—Slawyk. (*Deutsche Med. Wochenschr.*, 1898, No. 17.) Koplik, New York, in the *Archives of Pediatrics*, of Dec., 1896, described an eruption in the mouth in the premonitory stage of measles. It is localised on the mucous membrane of the cheeks, and consists of shining red spots, within their centres very small bluish white efflorescences. Slawyk confirms the observations of Koplik, and draws attention to their great importance, as they enable the diagnosis of measles to be made at a very early stage, days before the general rash has appeared.

At Professor Heubner's clinic for children, at the Berlin Charité Hospital, Slawyk found "Koplik's spots" forty-five times in fifty-two cases of measles, and in another epidemic thirty-one times in thirty-two cases. Slawyk describes the spots as bluish white, slightly elevated, roundish, measuring .2 to .6mm, surrounded by a red lentiform margin. They occur mostly on the buccal mucous membrane, occasionally also on the lips, and they were once seen on the tongue. They number usually from six to twenty on each side, but they are occasionally more numerous, and they sometimes occur on one side only—a good illumination is necessary to make them visible.

The spots scarcely ever coalesce, and the rash can easily be differentiated from other affections of the mucous membrane. It somewhat resembles thrush, but is distinguished from this by the colour and the roundish shape of the eruption. They cannot be wiped off, but the whitish spots can be removed with forceps without giving rise to pain or bleeding. Microscopically examined, they consist of thick layers of buccal epithelium, partly fatty degenerated. Fibrin or any characteristic micro-organisms could not be found, though the examination in this respect was not exhaustive.

Koplik's spots were seen in measles only. In every case where they were observed they were followed by the characteristic morbillar eruption, so that now at the Berlin clinic any child showing these spots is at once transferred to the measles ward. They usually make their first appearance on the first or second day of the premonitory stage; they then increase in number for three or four days, and then disappear. Their abundance or rarity does not indicate the severity of the coming attack of measles.—*Medical Chronicle*.

Poisoned by Overcoats.—The men employed by the Birmingham Public Works Committee to clear the streets of snow were supplied with overcoats which, on becoming soaked by the sleet and rain, apparently gave off a poisonous fluid. As a result a large number of the men suffered from poisoned hands and arms, and had to be treated at the hospital. Sir James Smith, chairman of the committee, at a meeting recently, stated that about 60 of the Corporation employes have up to the present complained of the effects of the chemical dressings of the coats

and overalls. The garments were supplied by a Birmingham house, and a representative of the firm attended before the committee and explained that the cloth was obtained from a mill in the North. Dr. Hill, medical officer of health, has analysed the cloth, and he reports that it contains chloride of zinc. The garments, to the number of 300, have been called in, and the committee have decided to return them to the makers, and leave that firm to obtain redress for itself from the mill-owners. None of the men are seriously injured. They, in the majority of cases, suffered from a skin eruption on the arms, and hands, and thighs, caused by the zinc irritant.—*British and Colonial Druggist*, Dec. 2.

Urticaria of Mucous Membranes.—The eruption of urticaria does not affect the skin only, but may extend to the mucous membranes. On some patients it can be observed; on others its existence is to be inferred from the symptoms. Affection of the stomach usually shows itself by vomiting, but in a few rare instances hæmatemesis has occurred. In the *British Journal of Dermatology*, May, 1898, Dr. T. H. Chittenden has published the following case. An unmarried woman, aged 38 years, became subject to attacks of urticaria. They increased in severity, the tongue and lips became very swollen, there was sore throat with dysphagia and dyspnoea lasting three or four hours, and the mucous membrane of the nose was much swollen and congested. These attacks usually lasted about a week. Later they were accompanied by nausea and by vomiting of large quantities of blood, which was followed by relief and the disappearance of the rash. There appeared to be some relation between the catamenia and the hæmatemesis; the latter came on about the first day of the former. Menstruation for the most part was regular but very profuse. No cause for the disease could be traced; there was no family history of gout, asthma, or hæmophilia, and the strictest rules of diet had no effect. In the "Transactions of the Clinical Society of London," 1885, Dr. Pringle recorded an exactly similar case in a man; he concluded that the hæmatemesis was the result of capillary hæmorrhage from an urticarial gastric mucous membrane. In urticaria of the skin analogous hæmorrhage may take place into the wheals (urticaria hæmorrhagica). The

mucous membrane of the bronchi may be affected, and a typical attack of asthma may accompany the skin disease. Of this, a marked example was published in the *Lancet* of May 22, 1886, by Mr. T. Davies Pryce. Indeed, apart from such cases of concurrence, urticaria and asthma show many analogies. Idiosyncrasy plays the same prominent part in their causation. These facts lend support to the theory of the late Sir Andrew Clark that asthma is a neuro-vascular affection of the bronchial mucous membrane.—*Lancet*.

Urticaria of Mucous Membranes.—Thiliez and de Moncan (*Jour. des Sciences Méd. de Lille, Abst. Jour. de Méd. et Chirurg*, Oct., p. 792). A young medical practitioner had been subject to attacks of urticaria regularly every two or three months since the age of 12. The course was always the same. Suddenly there was pricking, soon followed by itching, of the eyes. The conjunctiva became red and swollen; the eyeballs projected, impeding shutting of the lids, which was also made difficult by swelling of the latter. At the same time as the ocular symptoms there was a sensation of tension and heat in the mouth, followed by swelling of the mucous membrane, rendering speech difficult. There was also deeply-seated pain in the back accompanied by cough and a sensation of suffocation. According to the severity of the attack, itching of the scalp and of the palms and hypogastric region, and in some cases of the whole body. The cause was unknown, and treatment was without result.

SURGERY.

Surgical Intervention in Hæmatemesis Consecutive to Exulceration of the Stomach.—Dieulafoy (*La Press Méd.*, Jan. 19, 1898) summarises his views on this subject as follows:

1. Besides the simple ulcer, which is a frequent cause of hæmatemesis, there is found a superficial loss of substance of quite large extent, which he terms simple exulceration.

2. This form of ulceration is capable of causing greater hemorrhage than is generally seen in the case of simple ulcers.

3. The loss of substance in simple exulceration does not go deeper than the mucous layer; it

takes in the muscularis mucosæ, however. The great and frequently deadly hemorrhage which results arises from the ulceration of one of the arteries which ramify in the muscularis mucosæ.

4. Clinically, the simple exulceration has the symptomatology of the simple ulcer as described by Cruveilhier, of which it no doubt is the initial stage; but more frequently it commences quietly and at the same time in a latent manner with moderately severe hemorrhages.

5. Surgical intervention is the preferable treatment for hemorrhages consecutive to simple exulceration. The abundance rather than the repetition of the hemorrhage is the indication for intervention.

The operator should never forget that the stomach may present an apparently sound appearance and yet be the seat in some part of a simple exulceration. It is therefore essential carefully to examine the entire stomach, if necessary, with a lens, to detect the exulceration, which is frequently accompanied by ecchymotic areas which are points of repair.

7. Suture of the area involved with a small margin of sound tissue usually suffices in these cases. The operative results are generally more successful in this form of ulceration than in the case of simple ulcers, as the limitation of the lesion favours the surgical method of treatment.—*American Jour. of Med. Science*.

Dorsal Luxation of the Thumb. Vitrac (*Rev. de Chir.*, July, 1898) has been led by clinical and experimental study of dorsal luxation of the thumb to recognise lateral displacement as an important and invariable complication of this injury. In a large majority of cases—about 95 per cent.—the displacement is inwards. The much rarer external dorsal luxation is caused by the application of great force to the thumb whilst extended and abducted. Of this special injury there are two varieties: the complete and the complex external dorsal luxations. In the former the axis of the first phalanx is perpendicular to that of the metacarpal bone. The phalanx is outside the middle line of the metacarpal bone, the head of which presents a marked projection in the first interosseous space. The long flexor tendon can be felt on the outer side of the thumb. In complex dorsal luxation the thumb is shortened, the long

axis of the phalanx is parallel to that of the metacarpal bone, and the long flexor tendon cannot be felt. In both varieties the lateral ligaments of the joint and the adductor and the inner bundles of the short flexor muscles are torn through. The great difficulty and in many cases the impossibility of effecting by ordinary means reduction of an external dorsal luxation of the thumb are attributed by the author to the displacement of the long flexor tendon. If the first phalanx cannot be reduced by manipulation the surgeon should have recourse either to exposure and replacement of the flexor tendon, or to division of this structure either above the wrist or at the seat of luxation. The writer is in favour of an operation that would expose the injured joint freely, and permit, besides replacement or division of the tendon, any other steps necessary.—*Brit. Med. Jour.*

The Treatment of Traumatic Renal Hæmorrhage.—Nasse (*Berliner Klin. Wochenschrift*, Aug. 22, 1898). A boy, aged 8, injured his back by falling off a horizontal bar, and passed bright bloody urine. After a fortnight he was extremely anæmic; there was a feeling of resistance in the right lumbar region from the twelfth rib to the crista ilii, and the urine was still brownish red. He remained in the same condition for eight days, then there was sudden retention of urine from a clot in the urethra, with collapse and acute anæmia. The bladder reached the umbilicus, and a fresh renal hæmorrhage which had filled the bladder with clot was diagnosed. After drawing off the blood by a catheter attached to a powerful aspirator, the kidney was exposed by a free lumbar incision. When the transversalis fascia was cut through a large blood cyst was found and incised. The coagulated blood and urine contained in it were removed; profuse arterial hæmorrhage followed. As the kidney was badly injured, and the patient could not endure further hæmorrhage, nephrectomy was performed after ligaturing the vessels and the ureter. Five weeks later the boy was perfectly well.

Traumatic hæmorrhage from the kidney nearly causes immediate death. More often the urine quickly clears. Sometimes, however, slight hæmorrhage continues, and this may prove fatal from anæmia. In other cases the urine

becomes clear or nearly so, but a swelling remains in the lumbar region. After days or months an acute dangerous hæmorrhage occurs as in the writers' case. These delayed hæmorrhages are probably due to traumatic aneurysms. Finally late hæmaturia may be due to the bursting into the renal pelvis of an encapsuled hæmatoma, then the blood is not bright red but coffee-coloured. The last is a favourable symptom.

Till recently patients with ruptured renal vessels were allowed to bleed to death. An operation is indicated for all profuse hæmorrhages, whether occurring immediately after the accident or later. The cases in which it is difficult to decide when to operate are the commonest, where there are slight but repeated bleedings. These mostly recover with rest; still, if left too long, a fatal result may ensue after weeks or months. The kind of operation must be decided by the case. A lumbar incision should always be preferred to laparotomy unless there are signs of blood in the peritoneal cavity. It is important to remember that these patients are always collapsed from loss of blood, and that rapidity is essential. Hence it may be better to remove a fairly sound kidney, than to have a long search for the bleeding vessel.

The Etiology and Surgical Treatment of Varicose Veins in the Leg.—Kraemer (*Münch. Med. Wochenschrift*, Sept. 20 and 27, 1898), gives an account of modern views on this subject. The first part of his paper is devoted to the etiology of varices. (1) Mechanical causes, such as pregnancy, do not produce varices, but only oedema or slight dilatation, which does not constitute a varicose condition. (2) The formation of varices is due to a pathological condition of the internal saphena, which is probably congenital. (3) The general predisposition is mostly hereditary, and its presence can be recognised by the figure, such persons having long legs and being tall. (4) The congenital local predisposition consists in there being a deficient number, or a total absence, of valves in the saphena vein. (5) Such a defective vein may perhaps resist dilatation for some time through a thickening of its intima (compensatory endophlebitis). (6) When this deformity is present, varices follow naturally, there being in such a case

no valves between the right heart and the periphery. The part of the paper relating to treatment is of more general interest. There are practically three operations now practised. (1) Trendelenburg's, which consists in dividing the internal saphena vein between two ligatures above the junction of any large collateral branch. This at once does away with the hydrostatic pressure. Excellent results are obtained as regards the usefulness of the limb, though the varices do not actually disappear since the vein below the ligature is still permeable. This operation is indicated in not too severe cases, where the smaller veins only of the leg are varicose, and all the more the older the patient. (2) This consists in a combination of the above procedure with excision of isolated varicose nodules, and often gives better results than a simple Trendelenburg. (3) When the whole saphena from above downwards is varicose, the only rational cure is total excision of the whole vein. This is known as Madelung's operation. The chief incision reaches from a hand's breadth below Poupart's ligament to the ankle, and there are other incisions over the larger tributary veins. Any ulcers are at the same time swaped or excised. This operation is especially indicated in young persons.

Dangers.—Five writers have reported cases of thrombosis, and four cases of embolism, one of which was fatal (embolism of the lung)—all after Trendelenburg's operation. Not much has been written about Madelung's operation, and no fatal case has been reported. It must be borne in mind that the same dangers (embolism and thrombosis) beset every kind of operation on veins, and also that they are very liable to occur in varicose veins without any operation.

Excision of a Vesicula Seminalis.—C. Mansell Moullin, M.D., F.R.C.S. (*Brit. Med. Jour.*, Nov. 5, p. 1418).—This operation may be required for tuberculosis, cystic degeneration, or persistent pain consequent upon long-standing gonorrhœal inflammation.

A young man had gonorrhœa repeatedly, and acute prostatitis with one attack. The prostate was enlarged and painful; the urine was full of filaments of pus. The enlargement subsided, but thickening became evident around the vesiculæ, which were exquisitely tender. Emissions were

frequent and painful; sitting was uncomfortable. He was treated by stripping the prostate and vesiculæ, with the finger in the rectum squeezing out drops of pus. There was improvement, but the right vesicula remained hard, nodular, and tender. Erections were exceedingly painful, and the patient was despondent. Exposure, and, if necessary, removal of the right vesicula, were recommended. The patient was placed in the lithotomy position, and a sound passed. A horse-shoe-shaped incision was made across the perineum about an inch and a half in front of the anus. The perineal septum was cut across, the sphincter divided and turned down with the rectum, and the pubic portion of the levator ani cut through. The vesiculæ were exposed covered by recto-vesical fascia, which was divided. The right, very hard and adherent, was separated from the side of the ejaculatory duct, and detached from the bladder. The sphincter was united to the centrum tendineum. The vesicula was very hard and irregular. There was no evidence of tubercle; probably the condition was the result of chronic gonorrhœa. After the operation the patient could walk and sit without pain, and emissions were almost painless.

Intussusception: Laparotomy: Recovery. (University College Hospital, under the care of Mr. Rickman J. Godlee; *Lancet*, Nov. 12, p. 1262).—The *Lancet* remarks: "We have recently published cases demonstrating the value of early operation in intussusception, but the importance of adopting this method of treatment could not be more satisfactorily demonstrated than in the case reported below. The early age of the patient and the severity of the symptoms would soon have led to a fatal termination, and the difficulty with which the bowel was reduced by manipulation renders it impossible to believe that any form of injection or inflation could have effected the reduction. Inflation has its dangers: it has led to rupture, it may appear to succeed though the bowel is still tightly grasped, and by its use very valuable time is lost. For these reasons, and in view of the results obtained by laparotomy in many cases, it can now hardly be maintained that inflation is justifiable, except in cases where the parents refuse to allow a cutting operation. In Mr. Godlee's case the patient was

only six months old, and though recovery has been recorded in several instances at an earlier age, yet it is noteworthy how rapidly the child recovered, for he was discharged perfectly well on the seventh day."

A male infant, aged 6 months, vomited at six o'clock in the evening and at intervals until 10.15 p.m., when he passed "blood and slime." He cried a good deal, drawing up his legs. He was taken to hospital at midnight. Passing from the right side just below the costal margin to the epigastrium, a sausage-shaped tumour could be felt. It was tender, and moved with respiration. Laparotomy was performed. A large ileo-colic intussusception was found. The greater part was easily reduced, but the latter part required firm pressure.

Remarks by Mr. Godlee:—The case demonstrates the advantage of early operation. Had inflation been tried, the modification in the shape of the tumour would have suggested that reduction had been accomplished; but the operation showed that this was absolutely impossible. It was difficult to effect even at this early period after the onset of symptoms; and a few hours' delay would have probably rendered excision of part of the gut necessary.

Suture of the Left Auricle.—Giordani (*Rif. Med.*, Sept. 10, 1898) reports the case of a man, aged 35, admitted to hospital on July 9th with a knife wound in the antero-internal aspect of the left axilla directed inwards and downwards across the second intercostal space. He was blanched and pulseless. The writer, without an anæsthetic (as the patient was almost moribund), opened up the wound as far as the left margin of the sternum, and resected part of the third and fourth ribs. A large quantity of blood was removed from the wound, and it was seen that there was a free opening in a transverse direction in the pericardium, and, deeper still, a wound of the left auricle. There was also another smaller wound in the anterior surface of the pericardium. All these wounds were rapidly sutured, and a portion of the fourth rib removed for drainage. The patient lived until July 26th, and then died from septic bronchopneumonia. Pleurisy and embolic abscess in the right lung were found at the necropsy. The

wound of the auricle had completely united, and showed a good cicatrix. The pericardium was adherent to the heart. The part of the left lung covering the pericardium also showed a cicatrised wound.—*Brit. Med. Jour.*

Dilatation of the Stomach: Pyloroplasty and Gastrorrhaphy: Cure.—Westminster Hospital, under care of Drs. Allchin and Murrell and Mr. Spencer (*Med. Press*, Nov. 2, p. 456). A housemaid, aged 35, had suffered for three months from pain and vomiting after meals. Rectal feeding was adopted; she lost weight, weighing on admission 4 st. 8 lb. The stomach note extended to the umbilicus. During three months the stomach was washed out daily with boracic acid solution, six or seven pints of fluid being often evacuated. The patient was fed almost entirely by the rectum, any attempt at taking solid food being followed by return of pain and vomiting. As she was losing ground an operation was decided on.

Laparotomy was performed by Mr. Spencer. The stomach was found much dilated, thickened, and scarred. The pylorus was involved in a mass of scar tissue; its aperture was much narrowed. Pyloroplasty was performed to enlarge the pylorus and gastrorrhaphy to reduce the stomach. The patient recovered, and three weeks afterwards was taking solid food.

Dislocation of Both Hips.—Mauclair and Prevost (*Gaz. des Hôpitaux*, Oct. 29, p. 1144). A lighterman seeing another boat about to collide with his, endeavoured to push it back with his extended legs, and was thrown backwards. He sustained symmetrical iliac dislocations of the hips. Cases of dislocation of both hips are rare; they usually occur in workmen surprised by land-slips.

The Use of Gloves while Operating.—Opitz (*Berliner Klin. Wochenschrift*, Sept. 26, 1898) warmly recommends that sterilised linen gloves should be put on before operating, after strict disinfection of the hands, since experiments have shewn that it is impossible to render the skin of the hand absolutely sterile. Küstner, Mikulicz, and Winter, have all reported favourably on them. Döderlein, however, discovered bacteria on the

gloves after an operation, but these, in Opitz's opinion, were not derived from the operator's hands, but from the peritoneal cavity, whence they had penetrated from the surface of the operator's body and the air. When soaked through, the gloves are exchanged for a clean pair, the hands being again disinfected. In the rare cases where there is no time for a thorough disinfection of the hands, Opitz considers that india-rubber gloves are preferable to linen.

The Treatment of Soft Chancres by Dry Heat.—Körsing (*Berliner Klin. Wochenschrift*, No. 32, p. 718) has treated forty cases of soft chancre by Andry's method. This consists in applying caustic heat from a galvano-cautery, which is not brought into actual contact with the tissues, but held for 10 to 15 seconds at a distance of 1 to 2 mm. The edges of the ulcer must be most carefully heated, since it is here that the morbid process is most active. The ulcer must previously have been carefully cleansed, any undermined margin being snipped off, &c., so that the heat can penetrate deeply. No slough forms, but the tissues swell up, and their surface is bathed in the exuded serum. All healthy tissue is preserved.

Körsing had excellent results. In fifteen cases with inguinal buboes, the latter disappeared rapidly. One application is generally sufficient to ensure healing, though occasionally two or even three may be required.

Rhinoplasty for Æsthetic Reasons:—Jacques Joseph (*Berliner Klin. Wochenschrift*, Oct. 3, 1898) performed an operation, which he calls "rhinomiosis," to reduce the size and improve the appearance of an abnormally prominent and hooked, but otherwise healthy, nose. There were three stages. (1) Removal of that part of the skin which would not be required for the new and smaller nose, and also diminishing the anterior nares. This was accomplished by making two straight incisions, starting at the same point in the middle of the root of the nose, but then diverging and ending at the nares below, together forming an inverted V. These were made down to the nasal bones above, but through the whole thickness of the alæ nasi below. Further, two other incisions, also forming an inverted V, were carried upwards through the whole thickness of the alæ

nasi from one-fifth of an inch in front of the lateral termination of the first incisions below to meet in the middle line three-fifths of an inch above the tip of the nose. Everything between these two incisions was removed down to the bone above, and below, including the portions of cartilage which had been incised. (2) Removal of the superfluous part of the anterior roof of the nose, boney and cartilaginous. For this purpose the edges of the remaining skin were raised from the underlying bone and cartilage for two-fifths of an inch. A slit was then made through each nasal bone and the septum with the chisel, in the direction the new bridge was to take. Into this slit a knife was passed at right angles to the septum, and was carried downwards and forwards to the tip, thus removing the too prominent anterior roof of the nose. (3) Shortening of the septum nasi to raise the down-curved tip. This was attained by excising a wedge-shaped piece of the lower part of the septum, the base of the wedge looking forwards. With this the operation proper ended. The two edges of cartilage, where the wedge had been removed in the septum, were then brought together by sutures, and lastly the skin incisions were closed. When sutured these skin incisions formed an inverted Y. The wounds healed by first intention, and the improvement in appearance, as shown by photographs in the original, was very striking. Joseph believed that he was the first to carry out such a procedure, but has since discovered that Robert Weir, in America, performed an operation for the same purpose in 1892, though by a different method and with an indifferent result.

Cantwell's Operation for Epispadias.—Herbert W. Page, F.R.C.S., St. Mary's Hospital (*Lancet*, Nov. 5, p. 1193).—This operation of Dr. F. Cantwell ("transplantation of the urethra" for complete epispadias with infundibuliform opening into the bladder, but without extroversion) deserves to be more widely known. His paper is published in the *Annals of Surgery* of December, 1895. The operation is either not known or not appreciated, for the most recent books make no reference to it, and yet it is admirable alike in its conception and in its practical value. Dr. Page has had one case only, but Mr. Clutton has had two or three, and has been successful. The principle of

the operation is to dissect up a mucous and submucous flap, composed of the open urethra, from the extremity of the glans backwards as far as possible into the infundibulum, to separate thereupon the corpora cavernosa from each other by blunt dissection, to form a urethral tube out of the aforementioned flap, and to secure it in its rightful place beneath the corpora, which are then united together. The infundibuliform opening is closed by prolonging the incisions for the urethral flap so as to surround it, and, by suture of the wounded surfaces thus made, to bridge over the funnel which leads into the bladder. The result is the creation of a penis modelled on natural lines, with a well-formed urethra on the under side, occupying, that is, its normal relationship to the corpora cavernosa. Furthermore, the effect of the operation is to produce a penis with a natural curve, hanging properly downwards instead of being turned up on the abdominal wall—a penis, in fact, which, in the process of growth, is calculated to be available for all the possible uses which may be required of it, and which immediately admits of natural micturition.

A boy, aged 10 years, had complete epispadias, with an infundibuliform opening above the pubes, from which urine was continually dribbling. The penis was small and ill-developed, and was turned upwards so that the glans lay over the mouth of the funnel. When pulled downwards it was seen that the penile portion of the urethra existed as a flat band of bare mucous membrane reaching from the dorsum of the rudimentary glans back to the bladder opening, where it was lost from view. The corpora cavernosa occupied the under side of the organ. An opening was made in the perineum, and a Watson's silver tube inserted in order that after the plastic operation the parts might be kept entirely free from the contact of urine. From this time forth the boy lived night and day in a warm boric bath. The plastic operation was undertaken two days later, and presented no difficulties save such as were entailed by formation of the urethra, and accurate suturing. The urethral flap having been freed from the corpora cavernosa on which it lay, was moulded into a tube upon a catheter, fine catgut being used for the sutures. The corpora cavernosa were separated from each other with singular ease, and their subsequent union, together with the fixation of the

new urethra in its rightful place beneath them, was made with finest silk. Finally, the skin along the whole length of the penis and over the infundibuliform opening was sutured with silkworm gut. A soft catheter was then passed by the natural route into the bladder, secured, and left there. The child gained considerable control over the urine, and emptied his bladder at will through the retained catheter. When discharged six weeks later, he was able to retain his urine all night; and the only defect, if so it may be called, was a slight tendency to contraction of the meatus, for which the daily passage of a catheter was recommended. The latest reports of his condition are in every way favourable, and he is now regularly at school.

Extensive Resection of the Pelvis.—Wolf (*Münchener Med. Wochenschrift*, Sept. 27, 1898) reported nineteen cases of extensive resection of the pelvis for tuberculous disease at the "*Versammlung Deutscher Naturforscher und Aerzte*." In thirteen the sacro-iliac synchondrosis was removed, in four the limb was amputated at the same time, and in two the entire half of the pelvis was resected. Abscesses were present in 80 per cent. of the cases. These were gluteal in 50 per cent., more rarely pararectal, or pointed under Poupart's ligament, or even anteriorly. For the diagnosis of sacro-iliac disease Wolf considers a history of even slight injury to be of great importance.

Probably many cases are unrecognised, or mistaken for malingering or some nervous disorder, until an abscess points. If there is any doubt an examination per rectum must be made, when tenderness over the joint is a positive sign of disease.

Naturally, such extensive operations as the above are both bloody and dangerous, but less radical procedures result only in permanent fistulæ. Of twelve of Wolf's worst cases seven were cured and five died. Radiographs prove that there is a rapid new formation of bone after pelvic resections.

A New Method of Restoring the Absent Function of Muscles in Infantile Paralysis.—Noble Smith, F.R.C.S. Edin. (*Lancet*, Nov. 5, p. 1196.) In muscular contraction associated with infantile paralysis—as when the calf muscles are contracted and their antagonists, the flexors of the foot, are paralysed—division of

the tendons of the contracted muscles is generally followed by improvement in the nutrition of the whole foot. Division of the tendo Achillis not only permits restoration of the foot to a natural position, but it also frequently causes increased warmth of skin and subcutaneous tissue and presumably of the paralysed muscles also. "I have found that the almost immediate effect of tenotomy of the tendo Achillis, with reduction of the deformity, has been to set up a distinct increase in warmth of the part which is apparent during two to three weeks or more, or whilst the foot is kept absolutely quiescent, and the warmth continues afterwards as a permanent benefit."

OPERATION ON THE PARALYSED MUSCLES.—"It occurred to me that if tenotomy of a sound muscle produces so great an improvement in nutrition in a neighbouring muscle weakened by paralysis, how much more direct an influence would tenotomy of the affected muscle itself have."

A girl, aged 7, had an attack of infantile paralysis two years ago. The extensors of the left toes were apparently entirely paralysed, and there was contraction of the calf muscles, so that in walking the heel did not touch the ground. Dr. Risien Russell reported that there was pronounced reaction of degeneration in the tibialis anticus and extensor longus digitorum. The tendo Achillis and tendons of the tibialis anticus, ext. prop. poll. and ext. long. digitorum were divided. In eight days there was movement of the tendons of the muscles previously paralysed. The patient made an excellent recovery, and can walk with a light temporary support.

It is obvious that such a procedure will not restore absolutely degenerated muscles, but it shows that the reaction of degeneration is compatible with some recovery.

The Frequency of Volvulus of the Small Intestine.—Volvulus of the small intestine is generally supposed to be rare; few cases are seen either at operations or necropsies. In the *Medical Chronicle* of June, 1898, Mr. Thorburn has published some cases which tend to show that this form of intestinal obstruction is not as uncommon as is supposed, and that spontaneous reduction may take place, so that neither operation nor necropsy reveals the cause of obstruction. Mr. Treves has already adopted this hypothesis as an explanation

of certain cases of acute intestinal obstruction, occasionally recurrent, which recover without surgical treatment, but neither he nor others have observed the condition. Three cases are narrated. Laparotomy was performed in a case of acute intestinal obstruction; a coil of small intestine was found rotated on its mesentery. It was readily thrown back into the normal position; in fact, it fell back as soon as it was handled. At the two ends of the coil, where the intestine crossed itself, the wall was pale and the lumen was contracted. These parts recovered their normal appearance under the eyes of the operator. A man suffered for five days from complete obstruction of sudden onset. Within a few minutes of palpation of the abdomen, while the question of operation was being discussed, the bowels were suddenly and freely moved. But the patient's prostration increased, and he died in six hours. A sharply defined segment of the ileum, 6 in. in length, black and gangrenous, was found. In the third case at a laparotomy Mr. Thorburn found about 18 in. of small intestine similarly affected. In the second and third cases there is no direct evidence of volvulus, but there is no other explanation of the gangrene, for there was no hernia, old-standing peritonitis, bands, or interference with the mesenteric circulation. In the Transactions of the North of England Gynæcological Society, 1895, Dr. Donald has published a case of sharply defined gangrene of 5 ft. of ileum, which caused death thirty-five hours after ovariectomy, and has adopted this explanation of a spontaneously reduced volvulus.

Spreading Traumatic Gangrene.—A. H. Tubby, M.S. Lond., F.R.C.S. Eng., and W. Southey Wright, M.R.C.S., L.R.C.P. (*Brit. Med. Jour.*, Nov. 5, p. 1420). Traumatic gangrene is seldom seen now. It usually occurs in those debilitated from alcohol or other cause. The following case is remarkable in that it occurred in a young healthy child, and in that operation resulted in recovery, although the trunk was affected.

A girl, aged 10, fell from a swing in a disused fowl house and sustained compound fracture of right radius and ulna. Antiseptics were used and splints applied. On the following evening there were smart tingling pains in the forearm, and redness and swelling around the wound, which was discharging a thin foul serum. Next morning the

hand was swollen and livid, and had lost sensation, and the child was delirious and muttering. At 3 p.m. the hand and lower half of the forearm were much swollen, immobile, bluish-black, insensitve, and gas could be felt crepitating beneath the skin. Around the wounds for an oval space of about 3 and 4 in. the tissues presented a whitish appearance, and were hard, and gave the impression of a recently frost-bitten part. From the wounds decomposed blood and gas escaped freely, and the stench was cadaveric. Sensation was lost to within 1 in. of the elbow, and the skin up to the shoulder was tense, hard, of a uniform coppery colour, but not boggy. It still retained sensation. There was an ill-defined line of limitation just below the shoulder, roughly corresponding with a section made through the shoulder-joint. On the trunk there was a dusky coppery patch of involved skin about 3 in. in circumference situated below the axilla and extending down towards the crest of the ilium. The pulse was 120, soft, and compressible, and the temperature was 100°. Amputation was performed through the middle of the arm. The subcutaneous tissue was drab and gelatinous.

The case is typical of the results following injection of the bacillus of malignant œdema into animals. This bacillus is anaërobic and found in garden soil. Fowls are particularly susceptible to it—a fact which perhaps has some bearing on this case.

The Surgical Treatment of Sciatica.—J. Crawford Renton, M.D. (*Brit. Med. Jour.* Nov. 5, p. 1402), records eight cases of sciatica successfully treated by breaking down of adhesions, the result, no doubt, of perineuritis. He recommends this operation when medicinal treatment fails, especially when the patient is free from pain whilst resting. Mere stretching of the nerve is not sufficient. This method has restored sufferers to comfort even after seven years.

The following is an illustration:—A man, aged 32, had severe sciatica for eight months. The sciatic nerve was stretched and several adhesions removed from its surface, with partial relief. The pain continued in the ischial region and over the external popliteal nerve, and in the popliteal space, whenever the patient walked. The sciatic nerve was exposed below the gluteus maximus, and

found surrounded by adhesions extending upwards to the sciatic notch. A large one (1½ in. square), extended from the nerve to the ischial region. These were removed. The external and internal popliteal nerves were also exposed, and a few adhesions were removed from each. The patient made an excellent recovery, and is now—two years after the operation—perfectly well.

The Suturing of Penetrating Wounds of the Heart.—L. Rehn (*Verhandlungen der Deutschen Gesellschaft für Chirurgie XXVI. Kongress, 1897.*) In hæmatopericardium the heart is not displaced backwards as stated in the text books, but lies close to the chest wall, which is shown by experiments on animals. The left fourth and fifth ribs should be temporarily resected near the mammary line, and the flap turned back upon the sterno costal joints, which exposes the anterior wall of the right and a large portion of of the left ventricles. By resecting the third and fourth ribs and a part of the sternum the right auricle is exposed. Suturing of a cardiac wound is facilitated by drawing upon the pericardium, whereby the heart is brought forward. The right ventricle must be sutured during diastole, the left during systole. The following case is an illustration:—

A man, aged 22, sustained a penetrating wound in the left breast, causing unconsciousness and collapse. He was brought to the hospital, covered with blood, in a state of collapse, deathly pale, and gasping for breath. Examination showed a wound one and five-tenths centimetres broad in the fourth intercostal space, on the left side, which was not bleeding. There seemed to be an increase of heart dulness towards the right side.

The patient grew worse from hour to hour. Dulness extended to the left pleural cavity and dyspnœa increased. Respiration became 76 per minute; as the cardiac dulness increased the pulse became poorer, and the necessity of operative interference became imperative.

After temporary resection of the left fifth rib, near the mammary line, and emptying the copious collection of blood from the thorax, a small opening was discovered in the pericardium. Through this opening venous blood was escaping. The clamp which was applied pulled out. Free

incision was then made, and the pericardium lifted up by clamps applied at the wound. This brought the heart up into full view. Its action could be seen perfectly. The diastole seemed to last longer than the systole. A wound one and five-tenths centimètres long, which was bleeding freely, was discovered in the middle of the right ventricle. This wound was closed by three interrupted silk sutures, and the bleeding immediately stopped.

It was observed that the finger could be pressed upon the wound to stop the bleeding without interfering, to any considerable degree, with the action of the heart; but the introduction of the needle and the drawing up of the suture each time caused a momentary stopping of the heart's action. The patient recovered.—*Annals of Surgery*.

Metastatic Tuberculosis of the Skin.—Naegeli (*Münchener med. Wochenschrift*, No. 15, 1898) reports a case of a woman aged 35 with advanced phthisis, in whom after the appearance of salpingitis numerous nodules of various sizes developed in the skin. They were situated most symmetrically on the thighs and elsewhere. After excision they were found to be tuberculous, and were situated deeply in the cutis beneath healthy epithelium. This case shows that tuberculous tumours can be secondary to chronic tuberculosis of internal organs, as well as occur in acute miliary tuberculosis.

Traumatic Pneumonia.—Pézerat (*Gaz. Hebdom. de Méd. et de Chir.* No. 61, 1898). Injury alone cannot produce inflammation of the lungs, but acts by raising the virulence of the pneumococci already present, and by decreasing the resistance of the tissues. The pulmonary symptoms are often masked by those due to the injury, and the pneumonia develops insidiously. A rise, or further rise, of temperature marks its onset, but there is no critical fall. The cough appears on the third or fourth day of the pneumonia; the expectoration is at first viscid and mixed with clots of blood, but later becomes rusty and less viscid if the case progresses favourably, or, on the other hand, fætid from gangrene of the lung. Dullness can usually be found from the beginning, but there is nothing characteristic on auscultation; the signs are very seldom those of croupous pneumonia.

The prognosis is grave: most cases end fatally. Among the complications are traumatic emphysema and pneumothorax as direct consequences of the injury; later abscess of the lung and empyema. The writer distinguishes four kinds:—(1) fibrinous lobar pneumonia, (2) fibrinous pneumonia with multiple patches of consolidation, (3) catarrhal or broncho-pneumonia, (4) interstitial or dissecting pneumonia.

Fatal Obstruction from the Murphy Button.—Tieber (*Wien. Klin. Woch.*, Oct. 6) reports a fatal case of obstruction of the lumen of the Murphy button by a plum stone, and comments on several other cases in which the button became blocked with hard fecal lumps. He concludes that the use of the button should always be preceded by washing out the stomach and evacuating the intestines to remove foreign bodies, and that liquid food should afterwards be given for some considerable time.

Pyloric Obstruction in an Infant.—C. Stern (*Deutsche Med. Wochenschrift*, Sept. 22, 1898) reports a case where an infant had suffered from birth from obstinate constipation, unrelieved by medicine, and very little by enemata, and constant vomiting. It was admitted to hospital when 5 weeks old, when it was extremely emaciated. It was observed that the vomited material was not bile-stained, and a diagnosis of an obstruction situated above the mouth of the bile duct was made. Laparotomy and gastroenterostomy were performed, but though a normal stool was passed after the operation the child died the same night. Post-mortem, a tumour was found at the pyloric, which proved to be simple hypertrophy of the circular muscular fibres. The author has collected twelve cases which occurred in infants from 30 days to 3 years old. After discussing the etiology, pathological anatomy, and diagnosis, he concludes that operation for the removal of the obstruction is justifiable, even in an infant, when the obstruction is absolute.

Abdominal Adhesions as a Cause of Pain.—It was Mr. Mayo Robson, we believe, who first pointed out that many instances of severe abdominal pain spoken of as neuroses were due to adhesions and capable of cure by operation. These

adhesions may affect the stomach, vermiform appendix, ovaries, Fallopian tubes, and omentum. One of the sequels of gastric ulcer is perigastritis, which may result in adhesions to the abdominal wall or other organs, forming sometimes a tumour which can be felt externally. In the *Boston Medical and Surgical Journal*, of Sept. 29, Dr. J. C. Warren has published a case in which such adhesions were the cause of much suffering that was removed by operation. A man, aged forty-one years, who had suffered for years from dyspepsia and severe paroxysmal attacks of pain in the epigastrium, was admitted to hospital. He was sallow and emaciated. There was a tumour in the right hypochondrium, hard and ill-defined, and seemingly attached to the abdominal walls. An incision 5 in. long was made parallel to the right costal cartilages at a distance of about an inch. On dividing the abdominal parietes the liver was found attached to them by a thick exudation of lymph. The gall-bladder and the pylorus were buried in adhesions. After these had been broken down palpation failed to detect anything abnormal in the stomach or duodenum. The stomach was incised near the pylorus and explored. No ulcer or induration was felt in the stomach, but a cicatricial band narrowed the pylorus, so that only the forefinger could be pushed through; the opening was gradually stretched so as to admit the ring finger also. Complete recovery followed.—*Lancet*, Oct. 29.

The Treatment of Hæmorrhoids by Suture.—W. Thelwall Thomas, F.R.C.S., (*Brit. Med. Jour.*, Nov. 26, p. 1609). The usual methods of operation are contrary to the spirit of modern surgery. Healing by first intention should be secured. The following method has given very satisfactory results. The patient is prepared for operation in the usual manner, and the sphincter is dilated. The piles are clamped, the clamp being applied in the long axis of the bowel (no special clamp is required). The bulk of the pile is cut away, leaving a small stump standing on the clamp. The treatment of this is the essential feature.

A piece of catgut, not too fine, about a foot in length, with a domestic needle at each end, is used for a suture. Commencing at the top end of the stump one needle is passed through until there is one-half the length of the suture on

each side with its own needle attached. A reef knot is tied on the stump, and the needle that is on the right side is brought over to the left and passed through the stump lower down and back again to the right. The needle that is on the left is taken over to the right and passed through the stump back to the left immediately adjoining the previous one. A reef knot is again made, and so on to the end of the stump making five or six crossings to the inch. This method of suture brings the cut edges of the mucous membrane tightly together, and its advantage over a simple continuous suture is apparent, each cross and knot making each segment independent of the next. The clamp is slackened, and occasionally, though rarely, it may be necessary to tie a small vessel at the top end of the stump. All the internal piles are thus treated.

External piles, which are always covered by a rugose fold of altered skin, are snipped off by scissors, without clamping, pointing up the bowel. If a small vessel bleeds, it is tied. The cut edges of skin are sutured by a continuous, or button-hole stitch of catgut. Too much of the anal skin must not be removed, and the skin must never be sutured in any other direction but that of a continuation of the long axis of the bowel, else cicatrization, leading to anal contraction, will follow. It will now be seen that there is no raw surface left to be irritated or to granulate, and no tissue to separate by sloughing.

Where there is a large prolapse of mucous membrane bearing piles Whitehead's operation is necessary. A common error is to remove the external sphincter, wholly or in part, and then blame the operation for incontinence of fæces, instead of the operator.

Folker, of Hanley, several years ago devised a special clamp, figured in *Arnold's Catalogue*, for suturing piles with a special needle and catgut. There is a casual reference to suture of external piles in Bell's *Manual of Surgical Operations*, 1888. Describing the treatment of external piles, he says, p. 317: "If the surgeon after excising a pile or piles will take the trouble to stitch up the wound with catgut, he will find the cure much more rapid and less painful than when this is omitted." Mr. Robert Jones, in the *Provincial Medical Journal*, August 1, 1893, advocates a method of clamp and suture on the same lines.

The writer has performed the operation thirty-three times, and the average length of time during which the patient was confined to hospital has been 10.3 days.

The Extraction of Foreign Bodies from the Nose in Children.—Felizet (*Jour. des Praticiens*, Nov. 19, p. 761). It may be found impossible to remove foreign bodies because the forceps slips or because they are inaccessible. During five years M. Felizet has employed a method by which he has removed foreign bodies of the most varied kinds—boot-buttons, beads, beans, paper-pellets, pieces of pencil, and even a porcelain doll's head. Rhinoscopic examination is not possible; the probe is the means of diagnosis. To remove the foreign body he injects a current of water at a pressure of two mètres into the opposite nostril, which, returning by the posterior naris of the affected side brings out the body or enables it to be seized.

Stab Wound of the Thoracic Duct.—**Recovery.**—W. H. Lyne, M.D. (*Maryland Med. Jour.*, September 10, 1898), reports the above condition in a negro aged 24. An oblique stab wound about one inch long, depth unknown, was found above and behind the left clavicle and parallel with the outer border of the sterno-cleido-mastoid near its attachment. A longitudinal wound of the thoracic duct was therefore possible. An abundant milky fluid was steadily escaping. The wound was cleansed with hot carbolised solution, and packed with iodoform gauze, and bandaged. On removing the dressing about seven hours afterwards, the escape of chyle had completely stopped, and the dressing was reapplied. Recovery was prompt, except for a slight suppuration. The patient was discharged nine days after his admission, complaining only of a slight stiffness of the left arm. He was seen two years afterwards in perfect health.

Genito-Urinary Gangrene, Peri-Urethritis, and Extravasation of Urine.—Dr. Jean Escat (*Annal de Mal. des Org. Genito-Urin.*)—The current view that the primary lesion in extravasation of urine is a sudden rupture of the urethra during vesical effort is not correct. Peri-urethral cellulitis and gangrene are the result

of septic infection pure and simple, and not of perforation of the urethral wall. In the majority of cases, a gangrenous cellulitis of bacterial origin is the primary lesion, and the extravasation of urine is a result.

There are three clinical types:—1. La forme foudroyante de gangrène génitale, described by Fournier and Emery.—It is met with in healthy young subjects, with normal urine and urinary organs; the gangrene attacks the prepuce, glans, and scrotum, but spares the urethra and corpora cavernosa; it is therefore superficial rather than deep. Its origin is ascribed to streptococcal infection from the prepuce or urethra, the method of entrance usually remaining undiscovered. Recovery is the rule. 2. A superficial form of gangrene (similar to the first,) described by Guyon and Albarran, in old debilitated patients with enlarged prostate, who are daily subjected to septic auto-catheterisation. It occurs apart from any extravasation of urine; it is superficial, begins on the prepuce, and spreads to the scrotum, and is usually fatal within a few days. Four different micro-organisms have been identified, one is the *Staphylococcus albus*. The urinary origin of the infection is shown by the fact that injection of the urine into animals is followed by gangrene. 3. A type of gangrene is described by the writer in which the urethra is mainly involved, and which results from the extension of septic infection from the urethra to the peri-urethral tissues. The urethra may slough partially or completely; on incising in the middle line of the perineum, the urethra may appear black, as if carbonised. Appearing clinically as a diffuse gangrenous peri-urethritis, it may simulate extravasation of urine, and has been erroneously described as such. It is most often seen as the final result of long-standing peri-urethral lesions in cases of stricture.

All forms of peri-urethral infection may develop in the absence of any obstacle to the flow of urine, and may be observed in patients with stricture, who have always been able to pass urine satisfactorily. Post-mortem examination has shown that the perforations of the urethra may be multiple, and may even be situated in front of the stricture. The number and locality of the perforations are determined by antecedent changes in the urethra and its surroundings, and not by vesical pressure.

Hallé and Wassermann drew special attention to the wide extent of the changes caused by stricture; the urethra is involved, from the meatus to the neck of the bladder, and from its mucous lining to the corpus spongiosum and peri-urethral muscles. The changes include tissue degeneration, sclerosis, obliteration, endarteritis, and other results of chronic infection. This sclerosed tissue is most liable to succumb to infection.—*Edinburgh Med. Jour.*

OPHTHALMOLOGY.

Experimental Quinine Amblyopia.—Dr. Schweinitz (*Ophthalmic Record*) remarks that quinine amblyopia was recognised as long ago as 1829, but that the study of complete cases of quinine amaurosis began in America in 1879, and so many cases have now been reported that from the clinical standpoint quinine blindness is one of the best-studied of the toxic amblyopias. The researches made by himself, by Dr. Brunner, and others, in animals and man show that the lesion in quinine blindness is peripheral; that, primarily, there is ischaemia of the retinal and optic nerve vessels, caused by their intense contraction; and that, if the blindness continue for a sufficient length of time, atrophy of the optic nerve and tract associated with vascular changes indicating vasculitis and endovasculitis ensue, followed ultimately by obliteration of the lumen of the vessels. Dr. Schweinitz, in his experiments upon dogs, found that from the first to the fourth week there was pallor of the discs and great contraction of the vessels during life, whilst examination of the optic nerve with the microscope revealed imperfect differentiation of the fibrous framework and spreading apart of the individual nerve fibrils which were varicose and beginning to be atrophic. At this time there were no changes in the vessels. Later, and about from two to three months after the onset of the blindness, the discs were white and the vessels were almost entirely obliterated when examined with the ophthalmoscope, and under the microscope there was practically complete atrophy of the optic nerve fibres, thickening and collapse of the nutrient arteries of the optic nerve, and occasionally (in two specimens) obstruction of the

central vessel of the nerve with a partially organised thrombosis. The atrophy extended throughout the optic nerve, chiasma, and tracts. Dr. Ward Holden, in a paper read at a meeting of the American Ophthalmological Society gives details of the examination of the brain and spinal cord. The optic nerves and eyes of numerous dogs were examined which had been killed at periods ranging from two hours to seven weeks after the first injection of quinine. It was found that as early as the third day after several toxic doses had been given some ganglion cells presented vacuolation, pallor, absence of chromophilic granules, and breaking down of the cell body, whilst analogous degenerative changes, such as the appearance of large globules of a myelin-like character, were observed in the nerve fibres. The number of cells and fibres so changed continued to increase, and on the seventeenth day the first changes in the optic nerve were noticed, consisting in the breaking down of the medullary sheaths in numerous fibres. At about the end of six weeks the ganglion cell and the nerve fibre layers had almost entirely disappeared, leaving large cavities, and the myelin globules were no longer present. Many of the fibres of the optic nerve were broken down, and the degeneration of the nerve could be traced up to its fibres in the external geniculate body and pulvinar. The researches of Dr. Holden, therefore, whilst supporting the statements made by Dr. Schweinitz, Dr. Brunner, and others, appear to demonstrate that in the first instance the effect of toxic doses of quinine is to cause spasm of the vessels, and as a result of the lessened but not obliterated blood-supply the less resistant elements of the inner layers, the ganglion cells, and nerve fibres break down, whilst the cells of the inner nuclear layer are not visibly affected. An ascending degeneration of the optic nerve fibres follows the retinal changes.—*Lancet.*

Amblyopia following an Extensive Burn Treated by Iodoform.—Terson (*Archives d'Ophthalmologie*, Oct., 1897) reports partial atrophy of the optic nerves following an extensive burn on the thigh, abdomen, and arms of a woman aged 48 which was treated with iodoform gauze. About three weeks afterwards the patient, who had no symptoms except headache, noticed a rapid failure of vision. She could get about with some diffi-

culty, but could not read very fine print. The disks were pale, especially in the temporal region. The macular bundles were evidently involved. $Vod = \frac{1}{8}$, $Vos = \frac{1}{8}$. The fields were not contracted peripherally, there was a central scotoma, not absolute; colours could be recognised, but they looked faded. Mooren in 1858 described eye symptoms following an extensive burn—retinal hemorrhages, neuritis, retinitis, and chorio-retinitis. Horner has recorded similar complications; Wagenmann mentions hæmorrhagic retinitis following a fall into boiling sugar. After a time the blood was absorbed, but the disks remained white. This case had been treated with iodoform. Hirschberg reports the case of a girl aged sixteen, who developed a central scotoma after treatment of hip-joint disease with iodoform and Valude a case of white atrophy following a burn and iodoform treatment.—*Boston Med. and Surg. Jour.*

Suprarenal Extract in Ophthalmology.

—Fromaget (*Journ. de Méd. de Bordeaux*, No. 15, 1898) has used a watery extract of suprarenal capsule in eye diseases. In catarrhal conjunctivitis it contracts the vessels, so that a few drops cause a most intense injection to disappear in a minute. In iritis and deep inflammation it is of no use, nor is it able to arrest hæmorrhage if at all violent.

Its action on the vessels is a useful aid to the application of cocaine to inflamed tissues.

The Etiology of Phlyctenular Conjunctivitis.

—Axenfeld (*Separatabdruck aus dem Bericht über die XXVI. Versammlung der Ophthalmolog. Gesellschs. zu Heidelberg*) has inquired into the part played by the strumous diathesis in phlyctenular conjunctivitis, and finds that it was certainly present in 90 per cent. of 200 cases. It is therefore a most important, and perhaps a necessary factor. Phlyctenules are, however, not a local tuberculous process, since animals cannot be inoculated with tubercle from them. They can certainly be produced by external irritants, such as injuries, overstrain of the eye, or catarrhal conjunctivitis. It might be thought that their cause was probably infection from without, chiefly by the staphylococcus. Axenfeld has examined sixty-four cases bacteriologically, and proved that this is not so. In thirty no bacteria were found at all, in the

rest a variety of organisms, generally a few cocci or xerobacilli. Whether conjunctivitis accompanies the phlyctenulæ depends chiefly on the condition of the glands at the margins of the lids, though even when these are infected with staphylococci the conjunctival sac is not necessarily infected secondarily. Lastly an examination of the secretion from the conjunctival tissues showed that in hypertrophic strumous catarrh staphylococci are very seldom present.

Pulsating Exophthalmos. — A. Graefe

(*Deutsche Med. Wochenschrift*, Oct. 6, 1898) publishes a case of right pulsating exophthalmos. The question of treatment was discussed at the recent Congress of Ophthalmology, and decided, in a sense generally adverse to ligature of the common carotid artery. Cohn's statistics, however, show that seventeen out of nineteen cases were cured by this treatment, and the present case is another in its favour. The patient, a Red Cross sister, had acute pain in the right eye and exophthalmos. There were enlarged retinal veins, but no pulsation could be detected till some days later. This exceptional delay in the appearance of pulsation was probably due to the rupture of the internal carotid artery into the sinus cavernosus being originally small, but later becoming enlarged. This view is supported by the fact that the subjective roaring and whirring in the right ear and right side of the head were not noticed by the patient till the pulsation appeared. The noises were purely subjective, and were never heard by Graefe. Another interesting feature of the case was that from the first all movements of the extrinsic muscles of the eye were entirely abolished, together with that of the sphincter iridis. The increased pressure in, and dilatation of, the sinus cavernosus was probably one factor in producing this paralysis, and dilatation of the veins in the superior orbital fissure, causing pressure on the nerves, another. After ligature of the right common carotid practically all the symptoms vanished. On the tenth day, however, the subjective noises returned, probably owing to the establishment of a collateral circulation. At the same time there was a typical choked disc, which pointed to thrombosis in the neighbourhood of the sinus, and to the probable manner of cure. Four months later the patient was perfectly well, the only reminder of

the former condition being a persisting paresis of the sphincter iridis without any paralysis of accommodation. As regards etiology :—Idiopathic pulsating exophthalmos is rare, and rarer in males than in females, with whom pregnancy seems to play an important part. Traumatic cases are commoner. In the author's case the occurrence of a large petechial spot showed that there was a tendency to spontaneous rupture of vessels, of which the internal carotid in the sinus, with its two sharp bends and weak adventitia, is one of the most predisposed.

The Operative Treatment of Ptosis.—Hirschberg (*Deutsche Med. Wochenschrift*, Sept. 29 1898) describes and figures five cases where he performed Birnbacher's operation for ptosis, caused by revolver shots in the right temple, with the most satisfactory results. The operation consists in making a horizontal incision above the upper border of the tarsal cartilage. After exposing the latter, a variable number, generally three, stout silk sutures are passed through the upper border of the tarsus, then under the skin to above the eyebrow, where they are passed through the skin from within outwards and tied over short pieces of drainage tube. These sutures are not removed before the twenty-first day. The result is that the upper lid is permanently raised, but the eye can be closed fairly well by the orbicularis. To prevent the eye-lashes irritating the cornea under the dressings, it is well at the operation to close the lids by passing a superficial suture through their margins. When the dressings are removed the eye-lashes should be stuck to the skin by collodion, and cold cream placed in the eye. The operation acts in two ways : (1) The function of the active frontalis is transferred to the paralysed upper lid by the strong silk sutures. (2) The paralysed lid is raised mechanically by being fixed to the dense connective tissue over the bone in the region of the eyebrows. The novelty and great advantage of the operation is that the tarsi are raised without excision of skin.

The Surgical Treatment of Ptosis.—At a meeting of the Academy of Medicine M. Motais introduced details of a new method for the treatment of ptosis. M. Motais considers that the anatomical and physiological connections of the

muscles which elevate the eyeball and the upper eyelid afford good grounds for supposing that the action of the one can supplement that of the other. Acting on this theory he has invented an operation which he has already practised in five instances. This operation, which consists in grafting the superior rectus to the eyelid, is, of course, of no use in those cases of ptosis where this muscle is paralysed as well as the levator palpebræ. Grafting the eyelid will suffice in most cases of ptosis, but where the eyelids are much thickened a combination of grafting and resection must be employed. The results obtained are practically perfect, the normal physiological conditions and movements of the eyelid being restored.—*Lancet*, Nov. 19, p. 1369.

Ocular Crises in Locomotor Ataxia.—Pel (*Berl. klin. Woch.*, Jan. 10, 1898), relates the following case. A man, aged 41, had tabes and commencing dementia. There were hæmorrhages in the skin over the course of the peroneal nerves after the lancinating pains. There were marked burning and stabbing pains in the eyeballs and neighbouring parts, powerful spastic contraction of both orbiculares, abundant secretion of tears, and reddened and swollen conjunctivæ. There was also hyperæsthesia in the skin round the eyes. Affections of the trigeminus are not so very rare in tabes, such as anæsthesia, hyperæsthesia, neuralgic pains, falling out of the teeth, etc.—*Brit. Med. Jour.*

OBSTETRICS.

Gauze Tamponade of Cervix for Hyperemesis Gravidarum.—F. A. Kehrer (*Centralblatt f. Gynakologie*, April 11, 1896) reports a case of hyperemesis gravidarum, for which he tried successively bromide of soda, tincture of nux vomica, cocain solution, and painting the cervix with nitrate of silver—all without success. Regulation of the diet, of the bowels, rest at night, and other hygienic measures were all resorted to, but the woman steadily grew worse, until it was decided to empty the uterus. In the thirteenth week, therefore, the cervix was packed with iodoform gauze, with the woman in Sims' position. The vomiting imme-

diately decreased, and in twenty-four hours ceased entirely. Abortion did not take place, and the woman went on for another twelve weeks perfectly well. Then vomiting began again as violently as before, and in the twenty-sixth week the gauze tamponade of the cervix was repeated. Once more the vomiting was greatly relieved, though not entirely stopped. A third time, in the thirtieth week, vomiting became so severe that the cervical tamponade was used, and following this the vomiting again ceased entirely. In the thirty-third week, the vomiting recurred, and Kehrler decided, as the child was viable, to terminate the pregnancy. He did so, obtained living child that thrived, and the mother made a good recovery.

Poisoning from a Carbolic Dressing of the Umbilical Cord.—M. Costé (*Gazette des Hôpitaux*, Nov. 5, p. 1167).—A dressing of glycerine and carbolic acid applied to the umbilical cord of a new-born child soon provoked symptoms of poisoning, to which it succumbed. A dressing of glycerine strongly coloured with methylene blue applied to the umbilical cords of lambs produced greenish discolouration of the urine, which showed that the umbilical cord is capable of absorption—a fact to be remembered when antiseptic dressings are used.

Cæsarian Section.—Frank (*Münchener med. Wochenschrift*, Sept. 27, 1898) stated at the "*Versammlung deutscher Naturforscher und Aerzte*" that the old conservative Cæsarian section is now preferred to Porro's operation, which was the operation of choice in the early eighties. A point much disputed is the best position for the uterine incision. Frank, having performed the operation thirteen times with one death, claims that, whether the incision is sagittal or oblique, anterior, posterior or fundal, or extends into the lower segment of the uterus, there is no difference as regards life. It is a mistake to suppose that the site of the incision has any effect on the amount of hæmorrhage. This really depends on the position of the placenta, which would be most often involved at the fundus. The writer prefers an anterior incision extending deeply into the lower segment of the uterus (Kehrler's), for the following reasons: (1) Objectionable adhesions are least

likely to be formed afterwards. (2) The danger of sepsis is increased in all those cases which necessitate the uterus being drawn forwards, as in the fundal and posterior incisions. In the discussion which followed this paper Everke, who had performed the operation thirty-five times, said he believed the results of Cæsarian section were no more unfavourable than those after perforation, if the operation was done early enough, and that in favourable surroundings it was certainly to be preferred to perforation of a living child. If the case was seen still earlier he preferred to induce abortion. Symphysiotomy was technically difficult, no prognosis could be given as regards the life of the child, and afterwards the mothers were often unable to work. The most important detail in Cæsarian section he considered to be careful suture of the uterus, and he advised putting in two sets of sutures, one decidual and knotted towards the uterine cavity, the other, including deep and superficial, knotted on the peritoneal surface.

Rupture of the Symphysis Pubis during the Application of the Forceps.—Barand Keim (*Soc. d'Obst. de Paris, L'Indépendance Méd.*, Nov. 16, p. 366). The patient was a primipara with contracted pelvis. The head was impacted at the inlet. The forceps were easily applied; during traction a crack was heard, and the head suddenly descended. The symphysis was ruptured and the soft parts below it were torn. The vulvar wound was sutured, and a catheter was passed and retained. There was a deep tear occupying almost all the depth of the vagina on the right side, from which there was abundant hæmorrhage. The uterus and vagina were tightly packed, but oozing continued. The packing was re-applied but the oozing still persisted. The patient's state was serious. Iodoform gauze soaked in a 10 per cent. solution of gelatine was used; the hæmorrhage stopped. The patient died on the fifth day from septicæmia. There were recent vegetations on the tricuspid valve, and the blood contained the colon bacillus.

The Influence of the Puerperal Period on Ovarian Cysts. Gottschalk (*Anal. L'Obstétrique*, July, 1898). It is generally agreed that ovarian tumours should be removed during pregnancy, if discovered at

that time. They are likely to cause great difficulty during delivery, and they are further liable to undergo modifications during the puerperium. The principal changes are (1) the formation of adhesions, the result of slight inflammation due to pressure or bruising of the cyst during labour; (2) torsion of the pedicle; this is specially predisposed to by the rapid alteration in size of the uterus, and consequent diminution of intra-abdominal pressure after delivery; (3) infection of the cyst contents; this generally causes rise of temperature, and, if the cyst has not been recognised, may simulate puerperal infection. Sometimes the cyst may suppurate without any rise of temperature, and then, very suddenly, severe symptoms may arise. Gottschalk records a case of this kind.

The patient, aged 40, after 13 years' sterility, was delivered of a living child naturally. On the second day she had abdominal pain and symptoms of peritonitis, which, however, rapidly subsided. Nine weeks later she became very ill, with signs of severe general peritonitis. Operation was performed. A cyst of the right ovary was found with strong adhesions to the bowels and parietal peritoneum. The cyst was removed with some difficulty. It contained greenish pus, of foetid odour, and also in its upper part a quantity of offensive smelling gas. The pedicle had been twisted twice on its axis, and was formed of the ovarian ligament. There was in addition a localised intra-peritoneal collection of pus at the side of the uterus. The general peritoneum contained ascitic fluid. The patient recovered rapidly. It is interesting that the bacillus coli communis was isolated, in pure culture, from the ovarian cyst, whereas in the pelvic abscess, staphylococcus pyogenes albus was alone present. It is debatable which of these organisms was the exciting cause of the suppuration. It is well known, however, that the bacillus coli communis may produce purulent peritonitis and pyosalpinx, and in this case the dense adhesions uniting the cyst to intestine would readily allow the migration of the bacillus.—*Medical Chronicle*.

The Passage of the Uterine Sound into a Fallopian Tube.—Wheelton Hind, M.D., B.S., F.R.C.S. (*Brit. Med. Jour.*, Nov. 12, p. 1489). The following case is important

because it proves the possibility of this occurrence which has been suspected. When examining a case of dermoid growth from the left ovary, the sound passed for nearly eight inches. It could be felt on the left side, apparently immediately underneath the abdominal wall. The passage was very easy and the sound turned somewhat to the left and gave no pain. To clear up the question of where the sound passed it was inserted before making the incision when operating for the removal of the tumour. On opening the abdomen it was found that the sound had threaded the whole extent of the left Fallopian tube and was presenting at the orifice. This tube was removed with the ovary and growth, and the patient made a good recovery.

Potassium Permanganate in the Treatment of Fissured Nipples.—Dombrovsky (*Semaine Médicale; Nord Médical*, Oct. 15) recommends painting the nipples several times a day with a solution of the strength of from two to five per cent.

Axis Traction with Ordinary Forceps.—T. Archibald Dukes, M.B., B.Sc. (*Brit. Med. Jour.*, Nov. 5, p. 1390)—The simplest, easiest, and most powerful method of applying axis traction with ordinary forceps is not generally known.

The patient being in the ordinary left lateral position, insert the blades so that the lock falls together; let the handles assume their natural position, close to the symphysis pubis pointing forwards. Allow them to remain during the whole process of extraction in this, the position which they naturally assume, pointing more and more forward as the head descends. To extract, grasp the forceps at or above the lock with the left hand, and place the hollow of the right hand on the posterior surface of the extremities of the handles, so as to be able to push with the right hand and pull with the left, by an action somewhat similar to that used in making a stroke with a paddle. Then, keeping both arms the whole time rigid and extended, place your own chest, facing the patient, in the desired line of traction—which with head at brim is a straight line passing from the patient's umbilicus through her coccyx—and pull with your back from the coccyx.

By this means the whole force exerted is expended on urging the child's head towards the coccyx ; none is expended on stretching the vulva, in pulling the forceps out of their natural position, or in pressure on the pubes or other bony parts. No compression need be used unless the forceps are beginning to slip. Every motion of the head is readily felt.

Though his directions are incomplete, Galabin's method is of course mechanically correct if the traction is performed entirely with the arms. But fancy pulling an oar or anything else without using the back !

Both Galabin's method and also Tarnier's tractors need retraction of the perineum to perform axis traction ; but with a rigid perineum this is not always easy or possible. And when this can be done, the tension of the perineum alters the direction of the resulting force acting on the child's head.

By the method described there is no tension of the perineum to disturb the direction of the force applied. The whole strength can, when necessary, be exerted in urging the child's head in any desired direction, counter traction being made by the nurse to keep the patient on the bed.

Delivery of the After-Coming Head in Contraction of the Pelvis.—

Dr. Radojewski (*Deutsche Med. Woch.*, Oct. 20) records three cases in which he extracted the after-coming head by breaking up the brain through the vertebral canal and washing away the brain substance with a current of water. In his first case, the midwife had pulled away the body from the head. He had not a cranioclast, and after vainly endeavouring to extract the head with a hook, he passed a uterine sound into the skull through the spinal foramen, broke up the brain, passed an elastic catheter into the skull, attached it to an enema syringe, and injected water till the brain was washed away, after which the head was easily removed with the hook. In a case of transverse presentation in a primipara, whose conjugata vera scarcely exceeded five centimètres (two inches), he turned, but the head could not be extracted by moderate traction and external pressure. As the child was dead he divided the spinal column between the second and third dorsal vertebræ, broke up the brain partly

with a catheter and partly with a wire introduced through the spinal foramen, and washed away the brain with water, after which the head was easily withdrawn. Dr. Radojewski has devised an instrument, which is made by Evens and Pistor, of Cassel, called the "cerebrotome aspirator." It consists of a tube a foot long containing a spring $3\frac{1}{4}$ in. long, which projects more or less beyond the tube as may be required. The spring is used to break up the brain, is then withdrawn from the tube to which a syringe half full of water is attached, and the brain substance is removed by alternate injection and aspiration of the water.—*Lancet*.

GYNÆCOLOGY.

Obliteration of the Cavity of the Uterus from the Use of Steam.—

Otto von Weiss (*Centr. Bl. f. Gynækol.*, June 18). A woman aged 19 suffered from abundant metrorrhagia, for which steam was applied to the mucous membrane of the uterus during scarcely 45 seconds. Five months afterwards no trace of external os could be found. During an unsuccessful attempt to restore permeability of the uterus, the cervical canal was found partly preserved, but the uterine cavity had entirely disappeared.

The writer concludes that the intrauterine application of steam is by no means harmless, and should be reserved as far as possible for hæmorrhages in aged persons, at the menopause, in chronic endometritis, and inoperable malignant growths.—*Semaine Médicale*.

Extirpatio Vaginæ.—A. Martin (*Berliner Klin. Wochenschrift*, Oct. 3 and 10, 1898) recommends complete removal of the vagina and uterus for those extreme cases of prolapse of the uterus and vagina which resist all other treatment, including colporrhaphy. Briefly, the stages of the operation are as follows :—(1). A circular incision is carried through the vagina at the former site of the hymen, about $\frac{1}{2}$ cm. behind the orifice of the urethra in front. (2). A vertical incision is made in the posterior vaginal wall up to the fold of peritoneum forming Douglas' pouch. After ascertaining the position of the rectum, six sutures are passed through the skin margin of the circular incision on the one hand and through the peritoneum of

Douglas' pouch on the other, whereby the peritoneum is firmly joined to the external skin. (3) Anterior colpotomy is then performed, the bladder and urethra are separated from the vagina, and the plica peritonei anterior opened and sutured to the anterior part of the incision, whereby the bladder is raised and pushed forwards. (4). The lateral wall of the vagina is then raised from the underlying tissue as far as the cervix, the broad ligament is ligatured, and here also the peritoneum is sutured to the lateral part of the circular incision. After doing this on both sides, there is a funnel-shaped cavity where the uterus and vagina formerly were, which is completely covered in by peritoneum, and by the tension of the remains of the ligaments the margins of the vulva are drawn tightly inwards and upwards. The external opening of this peritoneal funnel at the vulva is then closed by sutures, which draw the edges of the circular incision together, and the peritoneal surfaces in contact at the sides. Martin has performed this operation in ten cases, and always with most satisfactory results. A necessary condition for success is that the vagina be exercised completely, right up to the hymen.

PHYSIOLOGY.

The Hydrolysis of Proteids.—Dr. A. Eicholz (*Journal of Physiology*, No. 3, vol. 23) has endeavoured to determine how far a glucoside constitution could be held to cover the whole range of proteids. He prepared, in as pure a form as possible, the proteids from egg white, serum and milk. These were then boiled with 10 per cent. sulphuric acid for a number of hours, and the product tested, by means of phenyl hydrazine, for the formation of osazones. He found that egg white consists of three proteids (ovo-mucoid, egg-albumin and ovo-mucin), each of which yields an osazone, and may therefore be regarded as having a glucoside constitution. Pure casein and pure serum albumin yield no osazone, but serum globulin does. The writer concludes that glycoproteids are very widely distributed; but is unable to agree with Pavy—that *all* proteids are of this class, since pure serum albumin and pure casein resist all attempts to produce from them a definite

osazone-yielding sugar. Apart from the theoretical interest of this paper, it has important bearings on the pathology and the treatment of diabetes; for if sugar-yielding proteids are so widely distributed, one need not be surprised that in cases of severe diabetes, sugar can still be excreted, even though there be no carbohydrate in the diet. The fact that casein yields no sugar, singles it out as specially suitable for dietetic use in cases of severe diabetes.

On the Presence of Bacteria in the Healthy Air Passages.—Dr. Jundell (*Skandinavisches Archiv. f. Physiologie*, Bd. viii., Hft. 4 and 5, Oct. 20, 1898).—By means of a specially-constructed pair of forceps, carrying a plug of sterilised wool protected by a shield, the writer was able to obtain fragments of mucus from the air passages below the level of the vocal cords the manipulation being facilitated by previously spraying the pharynx and larynx with a sterilised solution of cocaine. Forty-three healthy persons were examined in this way. The results showed that in all of them the respiratory passages below the glottis were either completely sterile or contained only a small number of bacteria. The writer discusses the possible explanations of this rather surprising result, but without being able to arrive at any satisfactory conclusion. His results harmonise with the notorious experimental difficulty of producing general bacterial infection *viâ* the air passages.

The Functions of the Liver in the Metabolism of the Nucleins.—Dr. G. Ascoli (*Archiv f. d. Gesamte Physiologie*, 72, p. 340, 1898). The writer passed solutions of uric acid through the liver in dogs, and found that a good deal of the uric acid disappeared in the course of the experiment, while the proportion of urea in the blood leaving the liver rose. He infers that the liver of mammals (in contradistinction to that of birds, &c.) must be regarded as a destroyer, rather than a producer of uric acid. His observations are of interest as lending some support to the view that defective hepatic activity may be one explanation of the accumulation of uric acid in the blood in gout. (*See Metabolism of the Nucleins under Physiological and Pathological Conditions*, p. 154, No. II.)

NEW BOOKS.

AN ATLAS OF BACTERIOLOGY. By Chas. Slater, M.B., M.R.C.S., F.C.S.; and Edmund J. Spitta, L.R.C.P., M.R.C.S., F.R.A.S.—London: The Scientific Press, Ltd., 1898. Price, 7s. 6d.

This Atlas supplies a systematic series of photographs of bacteria, and what is of more importance, of their most characteristic appearances on culture media. It will be found of great value in the laboratory as a standard illustration of the various important bacteria and their cultures. The photographic reproductions are excellent, especially those of the typhoid bacillus showing flagella, the anthrax gelatine stab culture, and the bacillus coli culture in glucose gelatine showing gas production. In every respect this work is a valuable addition to the publications on bacteriology.

It is somewhat surprising, however, to find that the name of Roux is not specifically mentioned as one of the chief promoters of our knowledge of the antitoxic action of the serum of immunised animals.

With regard to the bacteriological diagnosis of diphtheria, it is quite unnecessary to wait more than 12 hours before examining the serum. If it is kept at 37° C. it will rarely be found necessary to wait 18 or 24 hours as the writers suggest. Rapidity of diagnosis being generally important in actual practice, it might have been mentioned that in the great majority of instances in which Diphtheria Bacilli are present the surface of the serum acquires a ground-glass or steamed appearance within about 12 hours, indicating the presence of colonies which may be picked up by a platinum needle, mounted, stained and microscopically examined, and that for still more rapid work, colonies on serum in petri dishes may be discovered by means of the microscope long before they are visible to the naked eye.

An Atlas is in no sense a text-book, and in a work of this nature, it would, perhaps, have been better to have included no more text than was absolutely necessary for describing the photos.

On page 73 preference is given to serum, yet both the diphtherial cultures depicted are said to have been made on gelatine, a medium but seldom used in diphtheria work; and though there is a striking difference between the appearances of these two cultures, no explanation is offered. The difference is probably due to their respective ages, whether they were made by swab or by needle, or at what temperature they were incubated. These are details, but they are important ones in practical bacteriology, and should not have been overlooked in a work of this kind.

Again, the diphtheria cultures being presumably pure, give the impression that diphtheria bacilli

are commonly found unassociated with other organisms. In actual practice, however, this is exceptional. Various kinds of cocci are usually present, and by the time the diphtherial colonies are as far advanced as those in fig. 70, they tend to swamp the diphtherial colonies, and thereby not only blur the picture, but make the differentiation of the specific colonies a matter of considerable difficulty. The importance of noting the age of cultures, and more especially of comparing cultures of the same age, is apparent when we come to study the chapters dealing with bacillus typhosus and bacillus coli, for it is a well-known fact that a culture of bacillus coli of the same age as a similar one of typhosus gives a much more abundant growth. This is one of the chief diagnostic points between the two bacilli, and upon comparing figures 53 and 60, we find that the typhoid is much the more abundant, due doubtless to its having been a much older culture, or having been incubated at a more favourable temperature. We therefore fail to see how fig. 60 illustrates the statement on page 65 that the bacillus coli "shows an even greater tendency to form a filmy spreading growth," than typhoid.

Figure 25, showing tubercle bacilli in sputum, deserves special notice on account of the splendidly clear definition of the bacilli, and we think it would have been better to have used more frequently throughout the Atlas the lower power employed in producing this specimen.

Figure 81 is said to show a colony of 24 hours' growth, but, if we are not mistaken, this photo shows dozens of individual cholera colonies. It would have been more helpful to have had a short series of more highly magnified photos of a single typical cholera colony (plate culture) at different stages of growth.

Figure 82 is not wholly satisfactory, for it cannot be said to show anything characteristic of the three distinct zones of a 72 hours' cholera colony. The surrounding gelatine should, if possible, be included in such photos, for the depth of the liquefaction affords an approximate idea of the age of the colony.

But notwithstanding the few slight imperfections referred to, this work is a valuable addition to the subject of bacteriology, and, both in the study and more particularly in the practical applications of that rapidly progressing science, it will prove of very great service.

TROPICAL DISEASES. By Patrick Manson, M.D.—London. Cassell & Co. 1898. Price 10s. 6d.

The announcement of a book by Dr. Manson on tropical diseases could not fail to raise great expectations, and the book, now that it has appeared, fully justifies them. The first thought that strikes the medical reader on dipping into the

volume is the great number of diseases existing in hot countries, of which very little is said in general text-books, and he realises that it is only of recent years that much work has been done in this extensive field. English men of science have perhaps in days gone by hardly taken so prominent a place in this research as might have been expected, considering the opportunities afforded by the extent of the British Empire; but recently the work of Manson, Ross, and others has done much to remove this reproach. Dr. Manson's work on the malaria organism and on the *filaria sanguinis hominis* is well known to all, and the admirable account of these diseases in the present volume is only what was expected of him. The ingenious theory of the part played by mosquitoes in the propagation of malaria seems now established on a firm basis of fact; time has still to prove whether the same insect is responsible for the transmission of the *filaria* also. The curious periodicity exhibited by malarial fever presents another problem which is not yet solved: the suggestion made by Dr. Manson that it is the product of two factors, a cycle in the life of the parasite modified by a recurring set of conditions in the human body, is certainly ingenious, though not absolutely convincing. The important subject of Sprue, a disease little recognised in this country, but a deadly enemy in the tropics, receives due attention, and the chapters on dysentery, on yellow fever, on beriberi, and on abscess of the liver are full of interest. The illustrations throughout the book are, also, for the most part, admirable, the least successful, perhaps, being that of the "moist" form of beriberi, which is hardly as striking as it should be. The English of the book is, perhaps, open to criticism, being apparently influenced by Dr. Manson's familiarity with German writings. Such words as "apoplectic-like," "hæmoglobin-dissolving," "parasite-containing," seem to come from a Teutonic mint, and examples of the influence of German phraseology on the style of the book could be pointed out. A small error seems to occur on the first page of the book, where malaria is defined as "a protozoal organism of warm climates, which," &c. Surely malaria is a disease due to the plasmodium and not the organism itself. The printing and paper of the book are excellent, and the size of the volume is convenient for a text-book—advantages which outweigh a slight feeling of regret that so important a work should not present a rather more imposing outward form.

ON THE STUDY OF THE HAND FOR INDICATIONS OF LOCAL AND GENERAL DISEASE. By Edward Blake, M.D.—London: Henry J. Glaiser. Price 2s. 6d. net.

The author is to be praised for the industry with which he has collected a large amount of useful

information from a great variety of sources. The subjects treated are: temperature; dryness; moisture; tremour; the nails—form, colour, distortion, and disease; parasites; eruptions; whitlow; warts; keratosis; Heberden's nodes; Haygarth's nodosities; Dupuytren's contraction; clubbed fingers; pulmonary osteo-arthritis; acromegaly; secretions; sensation. The author says that "lupus erythematosus has, of course, no connection with any bacillus." Why he should pronounce so dogmatically on this point we do not know. The question has long been a vexed one among dermatologists. But although the tubercle bacillus has never been found in lupus erythematosus, the clinical evidence that the latter disease is connected with tuberculosis seems to us quite convincing. This evidence, as Mr. Hutchinson has pointed out, is stronger than in the case of lupus vulgaris, the tuberculous nature of which is not doubted.

THE MYSTERY AND ROMANCE OF ALCHEMY AND PHARMACY. By C. J. S. Thompson. London: The Scientific Press, Ltd. Price 5s.

Not long since, when modern science was flushed with the pride of its earlier successes, it was the custom to write and speak with scorn of the investigators of earlier times. Now, when increasing knowledge tends to make men humble, we have become less intolerant of writers like Roger Bacon, Paracelsus, John Erigena, Al-gazzali, and the older philosophers. The debt which astronomy, chemistry, and physics owe to alchemy and astrology is no longer denied. Mr. Thompson's work gives a gossip history of the origins of medical, surgical, and chemical sciences, though compiled without any pretensions to original research, and with all those limitations which the popular treatment of such subjects involve. Although it has long been the fashion to attribute most branches of knowledge to an Egyptian origin, recent discoveries evidence other and perhaps older civilisations as probable sources. Chaldean chronology has been carried back to a date quite as remote as that of Egypt, and Hittite hieroglyphic inscriptions, only lately discovered, show that the great Hittite Empire in Asia Minor and Syria, destroyed 717 B.C. by the Assyrians, had lasted for more than a thousand years. Among the book-cylinders forming part of the great library of the priestly college at Erech founded by Sargon II., 2000 B.C., are translations of old Accadian works into more modern Aramaic. As far back as 2000 B.C. the old Accadian language had become obsolete, and was preserved as Latin and Vedic Sanscrit are at the present day. Modern research points to Asiatic civilisations quite as ancient, if not more ancient, than that of Egypt; and it is a mistake

to assign to Egypt the glory of being the sole source of civilisation.

Mr. Thompson is disposed to accept this view, and refers to the early practice of medicine by the Chinese. Egyptologists find that a thousand years before the Exodus the Egyptians possessed an elaborate pharmacopœia, many of the remedies in which are still employed. Mr. Thompson points out that the Chinese used drugs, and sought for the *elixir vite* centuries before such occupations were known in Europe. He quotes from a treatise, supposed to have been written 1122 B.C., on the action of the heart in small-pox, in which the eruption is described, and some kind of inoculation is referred to as a remedy. While admitting the older sources of knowledge, we are driven to Greece as the real cunabula of the art of medicine. The professional etiquette of the Greek physician is indicated by the Hippocratic oath. Although not as valuable as Dupuy's "*Médecin et Mœurs de l'Ancienne Rome*," Mr. Thompson affords his readers an interesting insight into the early history of science.

ÆTIOLOGIE UND KLINIK DES ACUTEN GELENK-RHEUMATISMUS. (ETIOLOGY OF ACUTE ARTICULAR RHEUMATISM.) By Gustav Singer.—Wien u. Leipzig, 1898. U. Braumüller. Price 6 marks.

The discovery of the specific bacterium of rheumatism has often been announced, but a strict examination has always shown that no conclusive proof has yet been tendered. In this book the author makes yet another attempt to demonstrate the real cause of the disease. He employs two methods. That of the bacteriological examination of the urine, the blood, and the joints themselves, and the careful consideration of the clinical course of the disease. The bacteriological examination extended to 92 cases. He considers the examination of the urine as being of the greatest importance, and he gives, therefore, very detailed descriptions of the methods he employs.

The results of his examinations are shortly these:—Out of 85 cases in which the urine was examined he found pyogenic organisms in 49, that is in 57.6 per cent.; out of 60 cases in which he examined the blood pyogenic organisms were present in only 15; and out of the 21 cases in which the contents of the joint were examined they were present in only 2.

He explains the fact that the micro-organisms were so seldom found in the last case by suggesting that in many cases of acute rheumatism of the joints, the real inflammation is periarticular, and the exudation within the joint is only to be considered as a secondary inflammation. Pyogenic organisms were also found in many of the accidental complications of articular rheumatism—

those affecting the pleura, the lungs, the tonsils, the spleen, and the skin.

From this frequent occurrence of pyogenic bacteria in different organs and secretions in cases of acute rheumatism the author concludes that the organisms are directly concerned in the origin of the disease. In the second, the clinical portion, he considers the various visceral complications accompanying articular rheumatism, and in one chapter gives a specially interesting description of scarlet fever, gonorrhœa, typhoid fever, pneumonia, and influenza, all of which diseases he considers are related to pyæmia, and therefore to rheumatism.

Everything, according to Singer, goes to show, both from a bacteriological and clinical point of view, and also from the results of experiments on animals, that rheumatism is a result of infection by staphylococci or streptococci, and therefore is in reality a variety of pyæmia.

SELECTED ESSAYS AND MONOGRAPHS: TRANSLATIONS AND REPRINTS, NEW SYDENHAM SOCIETY, 1897.

The high standard of the publications of the New Sydenham Society is maintained. The most valuable monograph is Dr. Bruhl's contribution to the study of syringomyelia. The description of the disease is very complete, and will probably for many years be the chief work of reference on the subject. It is enhanced by notes and additions by the translators, Dr. James Galloway and Dr. Lindley Scott. The prevalent view of the pathology of syringomyelia is that the cavity in the cord results from softening of a new growth (glioma). The author agrees with this, but hesitates to adopt it exclusively. On the question whether the affection known as Morvan's disease is a form of syringomyelia he took the negative side at the date of publication of the present monograph (1890), but the evidence since accumulated has caused him to now incline to the opposite view, which the majority of writers adopt.

Dr. H. M. Thomas records a case of cerebrospinal syphilis in which the very unusual lesion, a localised poliomyelitis in the lumbar region, was present.

Professor Köbner points out that Pemphigus Vegetans in its evolution resembles pemphigus vulgaris. For in the latter disease the eruption may commence in the mouth weeks, months, and even years, before the first blebs appear on the skin—a fact which is but little known. An essay by Professor Neumann also on Pemphigus Vegetans is published. The vegetations have been mistaken for condylomata. The following are the distinguishing features:—They are encircled by the remains of a bleb wall; the partial loss of epidermis gives them a stippled appearance; and their course is chronic.

A number of writers state their experiences of yaws in the different tropical regions where it is endemic. They are Dr. Maxwell (Jamaica), Dr. A. Nicholls, J. S. Wallbridge, and C. W. Daniels (Fiji and British Guiana), Professor Achilles Breda (Brazil), Dr. M. Charlouis (Java). They all agree that the disease is not syphilis. The testimony of the last writer seems cogent on this point. He not only observed that a patient, the subject of yaws, had acquired syphilis, but he also successfully inoculated syphilis in another case, with the patient's consent.

Dr. William Osler's monograph on the Visceral Complications of Erythema Multiforme—a subject very imperfectly noticed by authorities—is important. In his eleven cases the following complications occurred: arthritis (7 cases), bronchitis (1), heart disease (1), epistaxis (3), gastro-intestinal vomiting, diarrhoea, colic, &c. (11), hæmatemesis (1), hæmaturia (1), hæmoptysis (1), melæna (4), nephritis (3), enlarged spleen (2). Three cases ended fatally. It is to be noted, however, that most of the cases would be described as purpura rheumatica or peleiosis rheumatica. But the author regards them—and we think rightly—as forms of exudative erythema.

An article by Dr. Duncan Bulkley, "On the Relation of Sleep to Diseases of the Skin," is reprinted. Dr. F. G. Shepherd describes a remarkable case in which a purpuric eruption ending in gangrene was apparently caused by the administration of 20 grains of salicylate of sodium three times a day.

Prof. Fournier discusses the relation of syphilis to general paralysis. In different sets of statistics he finds a history of antecedent syphilis in a proportion varying from 50 to 92 per cent., which certainly bears out his opinion that there is a most intimate connection between these diseases. He also writes on parasyphilitic epilepsy. The very subtle distinction which he draws between syphilitic and parasyphilitic lesions appears to be a real advance. The former are specific in their nature, the latter only in their origin, and therefore are capable of being produced by other causes than syphilis. Thus parasyphilitic epilepsy, like ordinary epilepsy, is produced and continued as an isolated symptom without other cerebral manifestations; is persistent, and does not yield to specifics, but is controlled only by bromides. On the other hand, syphilitic epilepsy is associated with other cerebral phenomena; rapidly loses its individuality in a complex symptom group, that of the specific encephalopathies; runs an acute course in the direction of recovery or death, and is frequently amenable to specific treatment. Professor Neisser contributes an article on the relation between early treatment and tertiary syphilis. His statistics support the view that early and efficient treatment protect against tertiary syphilis. He strongly recommends Fournier's intermittent treatment, continued for four years,

during which seven or eight courses are given. But he differs from that authority in preferring inunction or injection of mercury to administration by the mouth.

THE PRINCIPLES AND PRACTICE OF HYDROTHERAPY. A guide to the application of water in disease, for students and practitioners of medicine. By Simon Baruch, M.D. One volume, 442 pages, illustrated by 74 half-tone cuts. Price, muslin, \$4 net.—New York: William Wood & Co.

Unlike other works on hydrotherapy, this is written by a general practitioner. The first part deals with the mode of action of water in health, the second part with hydrotherapy. The various methods of applying water are described, and the therapeutic indications are given. The author points out the necessity of instruction on hydrotherapy in the medical schools, so that this valuable method may be taken out of the hands of laymen and empirics.

A TEXT-BOOK OF BACTERIOLOGY. By George M. Sternberg, M.D., LL.D., Surgeon-General U. S. Army. One large octavo volume, of 693 pages, illustrated by numerous full-page photographic and coloured plates, and by 200 engravings in black and colours. Price, in extra muslin, \$5.50; in brown sheep, \$6.50.—New York: William Wood & Co.

The author's manual of bacteriology has been a standard work since its publication in 1892. In order to supply the need of many practitioners and students, for a work less exhaustive yet complete on the practical side, the present text-book has been written. Descriptions of non-pathogenic bacteria and bibliography have been omitted, while the later additions to our knowledge of pathogenic bacteria have been inserted.

The work is illustrated by 200 wood engravings, printed in black and colours, by five heliotype plates, and four chromo-lithographs.

DES CORPS ETRANGERS DU COUDE D'ORIGINE TRAUMATIQUE.—Par le docteur Isidore Boeri. Thèse de Lyon, 1898. (Foreign bodies in the elbow of traumatic origin.)

This is a valuable monograph based on numerous observations. The author divides the foreign bodies into three classes:—1. Inorganic—bullets, grains of lead, splinters of wood, glass, &c. 2. Organic, for example, blood clots. 3. Organic of direct traumatic origin—portions of bone or cartilage. Organic foreign bodies are the most common, they most frequently consist of portions of the olecranon, next of the epitrochlea, the epicondyle and the condyle; least frequently of pieces of the head of the radius. The injury is usually severe;

it may be direct or indirect. The symptoms are pain, loss of movement and inflammation; the most important is difficulty of extension. Sometimes the symptoms occur only after a long interval, the injury is forgotten. The differential diagnosis must be made from dry arthritis; for this purpose, the history of injury is important. If there is only slight functional disability and no symptoms of arthritis, it is better not to interfere; otherwise the body should be removed by arthrotomy.

DISEASES OF THE CHEST, THROAT, AND NASAL CAVITIES, including Physical Diagnosis and Diseases of the Lungs, Heart, and Aorta, Laryngology and Diseases of the Pharynx, Larynx, Nose, Thyroid Gland, and Oesophagus. Two hundred and forty illustrations, with revisory appendix containing many important additions. Revised third edition. Octavo, 736 pages, price, muslin, \$4 net. By E. Fletcher Ingals, A.M., M.D.—Published by William Wood & Company, New York.

The object of this work is to present in a convenient form the known facts relating to diseases of the respiratory and circulatory organs. Fifteen chapters are devoted to diseases of the chest, fourteen to those of the throat, seven to those of the nose, and one to those of the thyroid gland and oesophagus. There is also an appendix containing useful formulæ.

THE MEDICAL AND SURGICAL USES OF ELECTRICITY. Octavo, 600 pages, 180 illustrations. Price, in muslin, \$3.75; leather, \$4.50. By A. D. Rockwell, A.M., M.D.—New York: Wood & Co.

This work is practically the ninth edition of Beard and Rockwell's "Treatise on the Medical and Surgical Uses of Electricity"; but, as Dr. Beard has long been dead, and has had no connection with the revisions since the second, the work is issued under the name of the present author only. The book has been thoroughly revised and mostly re-written. A feature is the enunciation of the doctrine that electricity is not merely a local stimulant, but exercises an influence over general and local nutrition. A chapter is devoted to the Röntgen rays. The section on static electricity has been entirely re-written, and greatly enlarged.

TUBERCULOSE RENALE.—Par le docteur Tuffier, No. 9 de l'*Œuvre Médico-Chirurgicale*, Paris, 1898. Br gr. in 8vo, avec figures, 1 fr. 25. Paris, Masson.

The object of the author is to co-ordinate all the facts of renal tuberculosis, and in the light of his own experience to give a complete account of the

disease. The work begins by a history of the subject, brief but comprehensive, then follows the pathological anatomy of the different forms with original illustrations. Very clear descriptions are given, both of the renal lesions and those which occur simultaneously or successively in the neighbouring organs. The etiology and symptomatology are fully exposed. In the treatment, on which the author is a recognised authority, indications for nephrotomy and nephrectomy are given with precision, the operations are described in detail, and the results are stated. It will thus be seen that the monograph is a valuable one.

FUNCTIONAL DISORDERS OF THE NERVOUS SYSTEM IN WOMEN. By T. J. McGillicuddy, A.M., M.D. One volume of 373 pages, uniform with the Medical Practitioners' Library. Profusely illustrated by wood engravings and two chromo-lithographic plates.—New York: William Wood & Co. Price, in extra muslin, \$3; flexible morocco, \$3.50.

This book is written from the standpoint of the general practitioner. Attention is drawn to functional disorders, which, though frequent, are not so minutely described as organic diseases. In the functional nervous derangements of women many uterine disorders are only part of a constitutional condition which requires treatment, and the uterine ailment disappears when the general health has been restored.

DRS. HARVEY AND DAVIDSON'S SYLLABUS OF MATERIA MEDICA. Revised in accordance with the B.P., 1898. (By William Martindale, F.L.S., F.C.S.) Tenth edition.—London: H. K. Lewis, 1898. Price 1s. net.

This is a very useful little book. The original authors compiled it for the use of students and candidates for the degree examination in the University of Aberdeen. It not only fulfils this purpose admirably, but also will be found useful by the practitioner desiring to refresh his knowledge of the essentials of materia medica. The fact that the work has been revised by Mr. Martindale is a guarantee of its value. To encourage the use of the metric system for prescribing, he has added the dose of each drug and preparation in metric terms. How much longer will conservatism prevent the adoption of a rational system of weights and measurements in this country?

The order of arrangement is:—Inorganic chemicals; carbon compounds, vegetable kingdom; animal kingdom. An original feature of the work, which must prove valuable to the beginner, is the indication by symbols of "Relative values." Two means are employed, one for primary articles, the other for galenical preparations. The primary

articles have four degrees of value, indicated by numerals: 1, 2, 3, 4. Thus Opium is marked (1), Cusso (2), Tragacantha (3), Prune (4). The galenical preparations have a higher or lower degree of value indicated by the use or omission of an asterisk. A second asterisk is inserted when any preparation has a special value.

LEHRBUCH DER GEBURTSHÜLFE (TEXT-BOOK OF MIDWIFERY). By Max Runge.—Berlin: Julius Springer, 1898. Fourth Edition.

The third edition of this text-book appeared as recently as Dec., 1897. A fourth edition is called for, not because it had become necessary to make a number of corrections and additions, but because of the many advantages offered by this popular work. The new edition is thoroughly up to date and includes the results of the most recent work in this branch of medicine. Several very instructive illustrations have been added.

SKIZZENBUCH ZUR EINZEICHNUNG VON AUGEN-PIEGELBILDERN. (SKETCH BOOK FOR DELINEATING OPHTHALMOSCOPIC APPEARANCES.) By O. Haab.—Munich; J. F. Lehmann, 1898.

Haab's sketch-book, which now appears as a second edition in a somewhat altered form, is intended to simplify as far as possible the recording diagrammatically of any important appearance seen with the ophthalmoscope. There are thirty loose sheets coloured to represent the fundus oculi, on some of which the papilla and retinal vessels are represented, so that it is an easy matter to draw in any morbid changes.

THERAPIE DER HAUT UND GESCHLECHTSKRANKHEITEN. (THE TREATMENT OF THE DISEASES OF THE SKIN AND URINO-GENITAL ORGANS.) By H. Kafka. — Munich: J. F. Lehmann, 1898.

The author has collected the prescriptions in common use in Dr. Mrazek's clinic in the Rudolph's hospital in Vienna, among which are included the newest drugs which have proved useful. The book can be recommended as a reliable aid to prescribing for these diseases.

ZUR AKUTEN ÜBERANSTRENGUNG DES HERZENS UND DEREN BEHANDLUNG. (ACUTE OVERSTRAIN OF THE HEART AND ITS TREATMENT.) By T. Schott, 3rd edition.—Wiesbaden: J. F. Bergmann, 1898.

In the third edition of this well-known work, the author brings forward further proofs of the

occurrence of acute dilatation of the heart, whether previously weak or apparently healthy, as a result of exertion. These for the most part take the shape of illustrations from skiagraphs, which demonstrate very clearly the enlargement of the shadow caused by the heart after wrestling, and even after a gentle bicycle ride. The proof is the more convincing because all these pictures were obtained from perfectly healthy individuals.

DIE TECHNIK DER SPECIELLEN THERAPIE FÜR AERZTE UND STUDIRENDE. (THE TECHNIQUE OF SPECIAL THERAPEUTICS).—By

Dr. Gumprecht.—Jena: G. Fischer, 1898.

This book is designed by its author for the use of the student, the practitioner, and the beginner in research work, and we may say at once that this ambitious purpose has been carried out successfully. Though doubtful and disputed points are discussed, Gumprecht never loses sight of the fact that his chief aim is to make his book of practical value. Thus purely specialistic technicalities are omitted. The sections are arranged according to the organs, beginning with the mouth and ending with the skin. The text is written in a lucid style, and is rendered clearer by the introduction of 181 illustrations.

THE DISEASES OF THE PERIPHERAL NERVOUS SYSTEM, by Dr. Bernhardt: LOCALISED FACIAL ATROPHY, by Dr. Möbins: THE NERVOUS DISEASES OF THE INTERNAL EAR, OF TASTE AND SMELL: AND TETANUS, by L. von Frankl-Hochwart; being Vol. XI. of Nothnagel's SPECIELLE PATHOLOGIE UND THERAPIE.—Vienna: A. Hölder, 1898.

This description by Bernhardt of the diseases of the peripheral nerves is one of the best we have, and is founded on a very careful and complete survey of the literature of the subject joined to the author's great personal experience.

The second part consists of a chapter by Möbins on local facial atrophy. According to him this disease is produced by a local irritant, possibly of bacterial origin, which penetrates either the mucous membrane of the mouth or the skin, and causes the latter to atrophy. The atrophy of the muscles, fat, bones, and nerves is a secondary phenomenon. He attacks most energetically the theory that the atrophy depends on a trophoneurosis of the trigeminal nerve.

This eleventh volume is altogether worthy of its predecessors. The last chapter, by von Frankl-Hochwart, especially is written in a most fascinating style, and is the outcome of years of observation and deduction.

SELECT LIST OF NEW MEDICAL AND SURGICAL BOOKS.

Published in Europe and the United States.

- ALETRINO (A.).—Twee opstellen over crimineele anthropologie. Amsterdam. 8vo. 6s.
- AMOËDO (O.).—L'Art dentaire en médecine légale, avec 70 figures et 32 tableaux dans le texte, gr. in-8vo, 12 fr, relié. Paris.
- Anuario Internacional de Medicina y Cirujia. Revista semestral, 2a serie, tomo 26. 5 pesetas.
- AUVARD (Dr.).—Cancer de l'utérus, 42 fig. Paris. In 8vo. 2 fr.
- BARLOW (W. S. L.).—A manual of general pathology for students and practitioners. Philadelphia. 8vo, cloth. 5 dols.
- BARUNCH (Sm.).—The principles and practice of hydrotherapy. New York. 8 vo. 5 dols.
- BEASLEY (H.).—Pharmaceutical formulary: synopsis of the British, French, German, and United States pharmacopœias, and of the chief official formularies. 12th ed. Ed. by J. Oldham Braithwaite. London. 18mo. 6s. 6d.
- Beitrage zur pathologischen anatomie und zur allgemeinen pathologie. Redigiert von E. Ziegler. 2. Suppl.-Heft. Jena. 8vo. Mit 4 lith. Taf. 8m.
- BOCQUILLON-LIMOUSIN (H.).—Formulaire des médicaments nouveaux pour 1899. Paris. in-18, 3 fr.
- BRESSON (J. N.).—Leercurus voor stotteraars. le brief. Leeuwen. 8vo. Met 1 afbeeldn. 10s.
- BROCQ (L.).—Traitement des dermatoses par la petite chirurgie et les agents physiques, avec fig. Paris, in 8vo, 5 fr.
- BOWHILL (T.).—Manual of Bacteriological Technique and Special Bacteriology. 100 orig. illus. London. Roy. 8vo. 21s.
- BROWNE (L.).—The Throat and Nose and their Diseases. 550 illus. in colour, mostly by author. With special assistance as follows: Anatomy, Mayo Collier; Nervous Diseases, James Cagney; Histo-pathology, Wyatt Wingrave. 5th ed. rewritten. London. Roy 8vo. 31s. 6d.
- BUCK (A. H.).—Treatise on Diseases of the Ear. 3rd. rev. ed. New York. 8vo. 3 dols. 50 c.
- Bulletins et Mémoires de la Société française d'ophtalmologie, 16e année, 1898. Avec fig. et 3 pl. Paris. In-18mo, 15 fr.
- CALLEJA (C.).—Compilación de la patología de Letamendi. Madrid. 4to. 9 pesetas.
- CASTEX (A.).—Maladies du larynx, du nez, et des oreilles, avec 140 fig. Paris. In-16, cart. 12 fr.
- CHOTZEN (Mt.).—Atlas der Syphilis und syphilisähnlichen Hautkrankheiten für Studierende und Aerzte. 9 u. 10 Heft. Hamburg. 4to. 3 m.
- CHRISTIANSEN (V.).—Om Urinens Giftighed speciell hos sindssyge. Kjobenhavn. 8vo. Ög. 6 Tavler. 12s.
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- CLOUSTON (T. S.).—Clinical lectures on mental diseases. 5th ed. Plates. Cr. 8vo. 14s.
- CRUET.—Hygiène et thérapeutique des maladies de la bouche. Avec une préface du professeur Lannelongue, cart. Paris. In-16, 4 fr.

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- DA COSTA (J. Ch.).—A Manual of Modern Surgery, General and Operative. With 386 Illusts. London. 8vo. 21s.
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- DORN (Rdf.).—Die Elektrizität und ihre Verwendung in der Zahnheilkunde. Leipzig. 8vo. Mit 137 Abbildgn. 5 m.
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- DUHRSSSEN (A.).—Die Einschränkung des Bauchschnitts durch die vaginale Laparotomie (Kollpocoeliotomia anterior). Berlin. 8vo. Mit 7 Abbildgn. u. 6. Tab. 7 m.
- DURING (le Dr. E. von).—Leçons cliniques sur la syphilis. Traduit de l'allemand et annoté par le Dr. Léon Derville. Avec 11 fig. et 16 pl. Bruxelles. 8vo. 10 fr.
- EDGREN (J. G.).—Die Arteriosklerose. Klinische Studien. Leipzig. 8vo. 8 m. 60 pf.
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- HOFMANN (E.).—Atlas of Legal Medicine. Edited by F. Peterson and A. O. Kelly. London. Cr. 8vo. 15s.
- JULIEN (L.).—Traité pratique des maladies vénériennes, nouv. édit. mise au courant avec fig. Paris. in-8vo, 20 fr.
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- MONDEVILLE (H. de).—La Chirurgie de maître Henri de Mondeville. Traduction contemporaine de l'auteur, publiée, d'après le manuscrit unique de la Bibliothèque nationale. Par le Dr. A. Bos. Premier tome. Paris. In-8. Cart., 10 fr.
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- ZUCKERKANDI (O.).—Atlas and Epitome of Operative Surgery. Edited by J. C. Dacosta. London. Crown 8vo. 12s. 6d. net.

BOOKS & MAGAZINES RECEIVED.

BOOKS.

- TROPICAL DISEASES. By Patrick Manson, M.D.—London: Cassell & Co., 1898. Price 10s. 6d.
- ON SO-CALLED SPASMODIC ASTHMA.—London: H. J. Glaisher, 1899. Price 1s. net.
- THE ERECTION OF A CONSUMPTIVE SANATORIUM FOR THE PEOPLE. From the German of Dr. Nahm. Translated by William Calwell, M.A., M.D., 1898.—Belfast: Mayne & Boyd. Price 2s. net.
- ACTIOLOGIE UND KLINIK DES ACUTEN GELENK-RHEUMATISMUS. By Gustave Singer.—Wein u. Leipzig, 1898: U. Braumüller. Price 6 marks.
- SELECTED ESSAYS AND MONOGRAPHS: TRANSLATIONS AND REPRINTS. — New Sydenham Society, 1897.
- THE MYSTERY AND ROMANCE OF ALCHEMY AND PHARMACY. By C. J. S. Thompson, M.D., London.—The Scientific Press, Limited. Price 5s.
- THE PRINCIPLE AND PRACTICE OF HYDROTHERAPY. By Simon Baruch, M.D. Price, muslin, \$4 net.—New York: William Wood & Co.
- A TEXT-BOOK OF BACTERIOLOGY. By George M. Sternberg, M.D., LL.D., Surgeon-General U. S. Army. Price, in extra muslin, \$5.50; in brown sheep, \$6.50.—New York: William Wood & Co.
- DES CORPS ÉTRANGERS DU COUDE D'ORIGINE TRAUMATIQUE. Par le docteur Isidore Bœri. Thèse de Lyon, 1898.
- DISEASES OF THE CHEST, THROAT, AND NASAL CAVITIES. Revised third edition. Octavo, 736 pages. Price, muslin, \$4 net. By E. Fletcher Ingals, A.M., M.D.—Published by William Wood & Co., New York.
- THE MEDICAL AND SURGICAL USES OF ELECTRICITY. Octavo, 600 pages, 180 illustrations. Price, in muslin, \$3.75; leather, \$4.50. By A. D. Rockwell, A.M., M.D.—New York: Wood & Co.
- TUBERCULOSE RENALE. Par le docteur Tuffier, No. 9 de *l'Œuvre Médico-Chirurgicale*.—Paris, 1898. Br. gr. in 8vo., avec figures, 1 fr. 25 c.—Paris: Masson.
- LEHRBUCH DER GEBURTSHÜLFE. By Max Runge.—Berlin: Julius Springer, 1898. Fourth Edition.

FUNCTIONAL DISORDERS OF THE NERVOUS SYSTEM IN WOMEN. By T. J. McGillicuddy, A.M., M.D.—New York: William Wood & Co. Price, in extra muslin, \$3; flexible morocco, \$3.50.

DRS. HARVEY AND DAVIDSON'S SYLLABUS OF MATERIA MEDICA. By William Martindale, F.L.S., F.C.S. Tenth Edition.—London: H. K. Lewis, 1898. Price 1s. net.

SKIZZENBUCH ZUR EINZEICHNUNG VON AUGEN-PIEGELBILDERN. By O. Haab.—Munich: J. F. Lehmann, 1898.

THERAPIE DER HAUT UND GESCHLECHTSKRANKHEITEN. By H. Kafka.—Munich: J. F. Lehmann, 1898.

ZUR AKUTEN ÜBERANSTRENGUNG UND DEREN BEHANDLUNG. By T. Schott. Third edition.—Wiesbaden: J. F. Bergmann, 1898.

DIE TECHNIK DER SPECIELLEN THERAPIE FÜR AERZTE UND STUDERENDE. By Dr. Gumprecht.—Jena: G. Fischer, 1898.

THE DISEASES OF THE PERIPHERAL NERVOUS SYSTEM. By Dr. Bernhardt.—LOCALISED FACIAL ATROPHY. By Dr. Möbins.—THE NERVOUS DISEASES OF THE INTERNAL EAR; OF TASTE AND SMELL; AND TETANUS. By L. von Frankl-Hochwart. Being Vol. XI. of Nothnagel's "Specielle Pathologie und Therapie."—Vienna: A. Hölder, 1898.

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- Archives of Pediatrics. Archives of Surgery. Archives des Sciences Médicales. American Journal of Ophthalmology. American Medical Journal.
- British Journal of Dental Science. British and Colonial Druggist. Bristol Medico-Chirurgical Journal. British Journal of Dermatology. Birmingham Medical Review. Boston Medical and Surgical Journal.
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- Dental Record. Deutsche Medizinische Presse. Deutsche Medizinische Presse. Dominion Medical Monthly.
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- Glasgow Medical Journal. Gazette des Hôpitaux. Galliard's Medical Journal.
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- Indian Medical Gazette. Information Gazette. International Journal of Surgery. Indian Lancet. Intercolonial Medical Journal of Australasia.
- Journal of the British Dental Association. Journal of the American Medical Association. Journal of Cutaneous and Genito-Urinary Diseases. Journal de Médecine et de Chirurgie. Journal de Praticiens. Journal de Médecine de Paris. Journal of Comparative Medicine and Veterinary Archives. Journal of Balneology and Climatology.
- Liverpool Medical and Chirurgical Journal. Lancet. L'Obstetrique. La Gynécologie. La Semaine Médicale. La Chronique Médicale. Lyon Médicale. L'Indépendance Médicale. Love's Medical Mirror. La Médecine Moderne. La Tribune Médicale.
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- Pharmaceutical Journal. Pacific Medical Journal. Physical Review. Pediatrics. Practitioner. Progrès Medical. Phrenological Journal.
- Quarterly Medical Journal.
- Revue Clinique d'Andrologie et de Gynécologie. Revue de Thérapeutique. Revue de la Tuberculose. "Review of Reviews."
- St. Louis Medical and Surgical Journal. Scalpel.
- Thérapeutic Gazette. Treatment. Therapeutische Monatschafte. Therapist. Tri-State Medical Journal and Practitioner.
- Wiener Klinische Wochenschrift. Wiener Medizinische Presse. Wiener Klinische Rundschau. West London Medical Journal.





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